SUNRISE DENTAL

EFFECTIVE DATE: APRIL 1, 2003

I, _____, HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVE THE
PLEASE PRINT NAME

OPPORTUNITY TO REVIEW OR, IF REQUESTED, HAVE RECEIVED A COPY OF THIS

PRACTICE'S NOTICE OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY

TO ASK ANY QUESTION I MAY HAVE REGARDING THIS NOTICE.

_____ _____

NAME DATE

DEAR PATIENTS,

PLEASE BE ADVISED THAT THE PATIENT OR RESPONSIBLE PARTY MUST KNOW HIS/HER INSURANCE PLAN. PLEASE BE AWARE OF YOUR PLAN'S:

*** YEARLY MAXIMUM
*** CO-PAYS, DEDUCTIBLES
*** UNCOVERED SERVICES
*** FREQUENCY LIMITATIONS

ALL FEES FOR THE ABOVE ARE DUE AT TIME OF SERVICE AND ARE PAYABLE BEFORE BEING SEATED. WE CANNOT BILL YOU. PLEASE DON'T ASK. ANY BALANCE INCURRED DUE TO GOING OVER YEARLY MAXIMUM, UNCOVERED TREATMENT, CO-PAYMENTS WILL BE THE RESPONSIBILITY OF PATIENT/RESPONSIBLE PARTY.

ANY ACCOUNT THAT REMAINS UNPAID WILL BE FORWARDED TO COLLECTION. WE RESERVE THE RIGHT TO CHARGE PATIENT FOR ANY FEES INCURRED FOR SUCH COLLECTION ACTIVITY.

OUR OFFICE POLICY PERTAINS TO *ALL* PATIENTS. WE CANNOT ALTER OUR POLICY TO MEET INDIVIDUAL NEEDS OF ANY ONE PATIENT.

ALSO, BE ADVISED THAT IF YOUR INSURANCE COMPANY SENDS YOU A CHECK FOR TREATMENT YOU RECEIVED IN OUR OFFICE, YOU MUST FORWARD THE CHECK TO THIS OFFICE WITHIN 14 DAYS, OR YOU WILL BE RESPONSIBLE FOR OUR FULL FEE FOR THAT DATE OF SERVICE.

DATE _____ SIGNED _____