Northland Smiles

Please read statements below, sign & date

AUTHORIZATION

I hereby request that payment of authorized benefits be made to Northland Smiles for services furnished to me. I understand that any portion unpaid or denied by my insurance company is my responsibility and will be paid by me according to Northland Smiles credit policy. I authorize the release of any information the dental benefits provider may require to determine the benefits payable. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature Date

CREDIT POLICY

I have received a copy of Northland Smiles Credit Policy.

I understand that co-pays and deductibles are due on the day of service.

Initial:_____

APPOINTMENT FAIL POLICY

We request a 24 hour notice on all appointment changes and cancellations. An appointment cancelled less than 24 hours before is a broken/failed appointment. I have read and understand Northland Smiles No Show or Failed Appointment Policy. I understand that upon having three broken/failed appointments without proper cancellation I will be dismissed as a patient.

_____ _____

Signature Date

OPERATORY PRIVACY POLICY

Due to limited space, HIPAA and Infection Control guidelines, only the patient being treated is allowed in the operatory.

To further respect the privacy of our patients, cell phones are not to be used for making or taking of calls or taking pictures in the operatory.

_____ _____

Signature Date