Vista Ridge Dental Arts Studio, LLC
Amy Moody, DDS, Rebecca Nunley, DDS

108 West Tenth Avenue, Johnson City, TN 37604
Telephone 423.979.1800 Email: info@vistaridgedentalartsstudio.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY AND PRACTICE POLICIES

PLEASE READ AND INITIAL EACH LINE

I understand a 24-hour notice is required to cancel or reschedule an appointment for myself or another member of my family. I understand failure to do so twice will warrant a warning letter and a third missed appointment will result in dismissal of myself (and family members) from the practice. If I (family member) am more than 15 minutes late, the appointment will be rescheduled and considered a missed appointment. Being late repeatedly can also result in dismissal from the practice.

_____ _____

Patient Signature(Parent/Guardian) *Date*

1_____ I understand that, if I do not have insurance, full payment is due at the time of my appointment by cash, check, money order, or Visa/MasterCard. I understand that account balances are subject to an interest rate of 1.5% after 30 days past due.

2 _____ I will provide insurance information on the first visit, and will provide updates to changes as necessary. I am responsible for any unpaid insurance balances and for familiarizing myself with my insurance benefits, deductibles, and maximum limits.

3 _____ As a courtesy, Vista Ridge Dental is happy to file all dental claims for you. I understand that if I do have insurance, all copays, estimated portions and deductibles are to be paid in full at the time of treatment before being taken back to the operatory. Additionally, I understand that account balances are subject to an interest rate of 1.5% after 30 days past due.

4_____ I understand that all TN Care/Cover Kids co-pays are due at the time of the appointment. Further appointments can be scheduled only after that payment is made.

5_____ I understand the parent /guardian who brings a child for treatment is responsible for that child's account balance.
If I am unable to bring any patient under the age of 18, I will notify the office that a designated adult will be bringing my child with a written authorization. I will also be responsible for any payment due at the time of the appointment.

6_____I understand the office policy that my child will be seen in the exam/treatment room without a parent present.

7_____ If choosing to utilize the prepay program, treatment can be initiated when 50% of treatment costs have been collected. I understand the remaining balance must be paid monthly with Direct Payments to a credit card and those arrangements are made in advance. Further treatment can be scheduled once balance is paid in full.

8_____ I understand there will be a service fee of $25.00 for any returned check, and that my account will be treated according to the Past Due Payment policy (provided in practice policies). Only when this is taken care of will I be able to schedule any further appointments.

9_____ I understand that if after 90 days I fail to pay any balance, or to make arrangements to pay any balance, my account will be turned over to a collection agency and that I am responsible for all collections and attorney's fees in addition to the account balance. I will be unable to schedule any further appointments until balance is paid in full. If my account is relinquished to collections, I understand that includes patient dismissal as well.

10_____I have received a copy of this office's Practice Policies and Notice of Privacy, and agree to the terms expressed above.

11_____Information about my dental care can be shared with: _____

_____ _____

Patient (or Guardian of Minor) Name of Minor Patient Date