



RICHARD KERNAGIS, DMD ♦ JENNIFER WYNN KERNAGIS, DMD

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____ have received a copy of this office's Notice
of Privacy Practices.

Please print name

Signature

Date

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices but, acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)



RICHARD KERNAGIS, DMD ♦ JENNIFER WYNN KERNAGIS, DMD

FINANCIAL AGREEMENT

Thank you for choosing dental excellence at FishHawk for dental care. We are committed to outstanding dental service with each patient's individual needs in mind. Please take time to read the following and initial each section.

- _____ Full payment or your estimated portion is due at the time of service.
- _____ We accept cash, checks, Visa/MasterCard, American Express and discover. We also provide low/no cost financing for qualified applicants.
- _____ Your Insurance plan is a contract between you and your insurance company. We are not a party to that contract. Dental Excellence at FishHawk will file insurance claims provided you have given us complete insurance information. Please be aware that any balance is your responsibility, whether your insurance company pays or not. In the event we have filed a claim with the information you have provided, and payment is not received within 60 days, the bill will become your responsibility.
- _____ During the course of your treatment, it may be necessary to provide services that your insurance company does not cover. The payment of these services is your responsibility. Further determinations of these services are strictly an issue between the insurance company and yourself.
- _____ The adult accompanying a child to the dentist is responsible for the payment of these services. This includes guardians, grandparents, siblings, babysitters or any other caregiver given permission to bring the child for services.
- _____ Any account over 90 days that goes without payment will be turned over to a collection agency, which is HIPPA compliant and adheres to all current legislation.

Signature of Responsible Party

Date

I, _____ give the following people permission to bring my son/daughter in to this office for dental treatment:

