*Summary of the HIPAA Privacy Rule*

*(Full copy available at the Front Desk)*

‘The major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public’s health and well being.’

I acknowledge there is a full copy of the “Notice of Privacy Practices”and I acknowledge the compliance of the office of *Petrie, Storer & Associates, D.D.S.*



***Our Commitment***

At *Petrie, Storer & Associates, D.D.S.,* we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us. We believe that our relationship with you needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

***Your Commitment***

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise. Your portion of your treatment is expected as the time of services. *For your convenience we do accept many forms of payments including cash, check, Visa, MasterCard, Discover and American Express; we also offer third party financing through CareCredit, which utilizes interest free programs and extended financing options.*

We will require that patients with self pay balances do *pay their account balances to zero or to arrange some kind of payment plan* prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss the optional payment plans available may call and ask to speak with any of the team leaders representing the office. *Patients with balances* ***over $100*** *must make payment arrangements prior to future treatment being completed.*

**Print Name: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**