Brian E. Barrett, D.M.D., P.C
3080 Hwy 231 Wetumpka, AL 36093
Phone/Fax: (334)512-0940

FINANCIAL POLICIES

1. **24 hour cancellation policy: A $50.00 missed appointment fee** will be charged to your account for broken appointments or appointments cancelled within 24 hours of your appointment time. If you cannot keep your appointment, you must give us a 24 hour notice.
2. **Agreement to Pay: Payment is due at time of service!** The undersigned accepts the fee charged as a legal and lawful debt and promises to pay said fee including any/all collection agency fees (33.33%), attorney fees and/or court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state. A **$30.00 fee** will be charge for all returned checks.
3. You agree, in order for us to service your account or to collect monies you may owe, Brian E. Barrett, D.M.D., P.C. *Family & Cosmetic Dentistry* and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use.
4. We bill your insurance as a courtesy to you. We **estimate your portion** to the best of our ability. With every insurance company having there own fee schedule, we can only give an estimate. The balance on the account is the patient's responsibility.
5. Re-Billing Service Charge: A **$5.00 fee** will be charged to your account for each month payment is not received on an outstanding balance.
6. After **3 missed appointments**, we reserve the right to dismiss you from our practice.

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Signature of Patient or Guardian	**Date**

HIPAA FORM

Consent for use and disclosure of health information
www.hhs.gov/ocr/privacy/hipaa/administrative

Section A:

Patient/Guardian giving consent: ______________________________

Section B: To the Patient/Guardian- Please read the following statement carefully
Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of the above mentioned use and disclosures in greater detail. We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

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Signature of Patient or Guardian	**Date**