Kansas City Pediatric Dentistry, LLC
3801 Southwest Trafficway
Kansas City, MO 64111
816-622-2000

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Financial Agreement

If you have dental benefits, we will help you receive maximum benefits by filing for you. We will expect payment of estimated co-pays, coinsurance and deductibles at the time of service. We accept Credit Card, Check and Cash. We utilize postal mailings along with texting and emails, as provided on patient info, to send statements and billing.

As a patient (or guardian of a patient), I understand that this office does not acknowledge agreements between parents accepting or denying responsibilities of services provided. We consider the custodial guardian/parent to be responsible for payment of services received.

Assignment of Insurance Benefits

I hereby assign benefits to be paid, on my behalf, to: Emily Drake DDS, Kansas City Pediatric Dentistry LLC. I understand and agree to be financially responsible for charges not cover or paid by my dental benefits.

Certificate

The undersigned certifies that I have read and understand the "Financial Agreement" and "Notice of Privacy Practices Acknowledgement" as stated above.

Patient Name _____

Parent/Guardian Name_____ Relationship _____

Signature _____ Date_____