

# ROOSEVELT DENTAL CENTER

1210 Roosevelt Avenue Mt. Vernon, WA 98273  
(360) 424-5650

**R. Charlie Collins, D.D.S., P.L.L.C. Ute J. Collins D.D.S., P.L.L.C**

## ***Acknowledgement and Consent***

### ***Health history***

I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the health history questionnaire fully and accurately to the best of my ability.

### ***Release of information***

I understand that the dentist may need to collaborate with other healthcare providers and/or third-party payors in order to provide the best standard of care for me. I authorize the dentist to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of dental care to third-party payors and/or other health care providers related to my care.

### ***Financial policies***

I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not the dental office's responsibility.

I understand that I am expected to pay what is due from me for my treatment on the day of service. When a child of divorced parents is seen, we will expect payment from whichever parent accompanies the child to their visit. I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement from the dental office for this, and I am expected to pay in full within **15 days** of receiving this statement.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policy. I understand that if my account is past due, a 1.5% monthly (18% APR) interest charge will be applied to my account.

I understand that if my account is not paid as agreed, the account may be transferred to an outside collection agency. If legal action is commenced to collect my account, at the request of either party, venue for any legal action shall be placed in Skagit County, WA. I agree that in addition to other charges authorized herein, I (we) will pay reasonable attorney fees.

I understand that my account will be charged a **\$50.00** fee for any dishonored check and that I must immediately pick up the check and pay the amount **in cash** including any fees.

I understand that these policies may be superceded by a written and signed agreement of an alternate policy specific to my account.

***Rescheduling/cancellation policies***

I understand that if I need to reschedule an appointment, or cannot make an appointment, I must give **48 hours** notice to the dental office. If I do not give adequate notice, my account will be charged a **\$50** cancellation fee. Please be aware that Monday is not a normal day of business for our office.

I understand that if I fail or cancel more than 3 consecutive appointments without appropriate notice, my active patient status will be reduced to emergency status, and I will be advised to seek an alternate dental provider.

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*Signature of patient (or parent/guardian if a minor)*

*date*

**RECEIPT NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have been offered  
(patient name)

and/or received a copy of Roosevelt Dental Center's Notice of Privacy Practices.

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*Signature of patient (or parent/guardian if a minor)*

*date*