Acknowledgement 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.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

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Dental Creations LLC
112 N. Willow St. Harrison, AR 72601
870-204-6974

Written Financial Policy

Thank you for choosing Dental Creations LLC. We want to deliver the best and most comprehensive dental care available. An Important part of this goal is to make the cost of care as easy and manageable for our patients, by offering several payment options.

Payment Options:

You can choose from

- Cash, check, Visa, MasterCard or Discover Card
- Convenient monthly payments from CareCredit
- Incremental payments to the office PRIOR TO TREATMENT until the services are paid for

Please Note

Dental Creations LLC requires payment prior to the beginning of your treatment.
If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, it is your responsibility to know your insurance policy and the service it covers.
Our treatment plans and any discussions pertaining to insurance are ESTIMATES ONLY.
You are ultimately responsible for payment of services provided by this practice.

If you have any questions, please do not hesitate to ask, we are here to help you get the dentistry you want or need.

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Patient Name (PLEASE PRINT)

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Patient, Parent or Guardian Signature Date

Dental Creations LLC
112 N. Willow St.
Harrison, AR 72601
Phone: 870-204-6974 Fax: 870-204-6975
Dr. Wanda McCaskey DDS, General Dentistry

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMANTION

Patient Name ______________________________

Patient Address ______________________________

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Patient Phone Number ______________________________

Alternative Phone Number ______________________________

I authorize Dental Creations LLC, to release any health information identifying me under the following terms and conditions.

1. Detailed description of the information pertaining to the following: **All health/ dental, accounting, or personal information.**
2. **Name of who may obtain the information released**

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Patient Signature: ______________________________ **Date:** ____________