Patient Financial Agreement

As a valued patient, we want to thank you for choosing North Town Dentistry as your dental service provider.

We strive to provide the highest quality of dental care using the most up to date technology and dental supplies. In order to continue providing our services with great success, we have changed the way we have been billing and collecting treatment fees. We offer a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, American Express.

As of October 1st, 2015, we require that the full balance and co-pays be paid at the time of appointment. We will communicate all recommended treatment options and associated fees prior to the start of treatment. We will try our best to stay within the limits of your plan but sometimes this is out of our control. Payment is expected at the time of treatment. **We cannot guarantee payment from an insurance company and any remaining balance left after insurance payment is the patient's responsibility.** A delinquent account impedes our ability to provide you with quality dental care that you deserve. **It is our policy that the guardian who accompanies your child to our office for treatment is responsible for payment of all services rendered.**

If for some reason you are unable to pay the full amount on the date of your appointment, a payment plan arrangement must be made with our administration team. We will expect balances to be made in full within 90 days. We will do our best to work with you regarding your financial status at our office.

If no payment has been made by 60 days, we will proceed with your account incurring interest charges. After 60 days of nonpayment your account will incur 2% interest. After 90 days of nonpayment your account will incur 19.99% interest.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusive for you. We understand there may be times when you are unable to keep you schedule appointment, however, we do ask that you provide our office with a 48-hour notice should you need to reschedule.

You can count on North Town Dentistry for first class customer service. Whether you are speaking to our friendly administration team, or to Dr. Sharma herself, our ultimate goal is to provide you with options and solutions that meet your needs and exceed your expectations.

We greatly appreciate your business and thank you for choosing North Town Dentistry for all your dental care needs. We look forward to serving your family for years to come.

Please sign below in acknowledgement that you have read and agree to the terms of your account.

_____	_____
Print Name	Signature
_____	_____
Date	Witness Signature

Patient Consent Form Collection, Use & Disclosure Information

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. We also try to be as transparent as possible about the way we handle your personal information. All staff members who come in contact with your personal information are aware of the sensitive nature of the information disclosed to us. They are trained in the appropriate use and protection of your information.

Attached to this consent form, we have outlined what our office is doing to assure that:

- Only necessary information is collected
- Information is only shared with patient consent
- Privacy protocols, storage, retention and destruction of your personal information complies with existing legislation and privacy protocols provided by our regulatory body, the Royal College of Dental Surgeons of Ontario and the law.

Please do not hesitate to discuss our policies with any of our staff members as we are all dedicated to ensuring you receive the best quality dental care.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes listed. If a new purpose arises, we will seek your approval in advance.

Your information may be assessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RPHA and for the defense of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the event, this kind of request is made, we will forward the information directly to you for review and consent.

When unusual requests are received, we will contact you for your permission to release information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision and the process.

Patient Consent

I have reviewed and understood the above information. I agree _____

_____ _____ _____

Signature Print Name Date

_____

Signature of Witness