S. ALBERT CAVES, D.M.D.
5900 RIVER ROAD, SUITE 302
COLUMBUS, GEORGIA 31904
706-571-0079

PLEASE READ THESE TERMS CAREFULLY.

REMEMBER THAT INSURANCE IS FILED BY THIS OFFICE AS A COURTESY AND IS "NOT" A GUARANTEE OF PAYMENT AND IS NOT BE BE CONSIDERED AS A METHOD OF PAYMENT. IT IS THE PATIENT/GUARANTOR'S RESPONSIBILITY TO PAY ANY DEDUCTIBLES OR PATIENT ESTIMATED PORTIONS AT TIME OF SERVICE. FOR ANY REASON INSURANCE DOES NOT PAY, I ASSUME FULL RESPONSIBILITY OF THE UNPAID CHARGES.

> *** PRICES, FEES OR BENEFITS QUOTED IN OUR OFFICE ARE ESTIMATES ONLY. FINAL CHARGES OR BENEFITS PAID BY INSURANCE WILL BE BASED ON WORK PERFORMED AND CLAIMS FILED AFTER WORK HAS BEEN COMPLETED.***

IF FOR ANY REASON THE ACCOUNT IS ASSIGNED TO AN ATTORNEY OR COLLECTION AGENT, THE PRACTICE IS ENTITLED TO ALL REASONABLE ATTORNEY'S FEES AND/OR COST OF COLLECTION.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINING LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT OF ANY CLAIM.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED TO THE PRACTICE NAMED ON THIS FORM. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

I UNDERSTAND THAT THE CHARGES OF THIS ACCOUNT REMAIN THE RESPONSIBILITY OF THE PERSON SIGNING THIS FORM, EITHER PATIENT, PARENT, GUARDIAN OR SPOUSE.

I FULLY AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES STATED ABOVE.

SIGNATURE: _____

DATE: _____

Continued On Other Side

BROKEN APPOINTMENT POLICY

I understand that S. Albert Caves, D.M.D. has a broken appointment policy, which states any appointments that are not kept and for which I do not give 24 hours notice of cancellation are subject to a $40 Broken Appointment Fee for each hour that the appointment is scheduled. I agree that I am responsible for the Broken Appointment Fee. I also understand that if I have three or more broken appointments in one year I could be placed on a pre-payment only basis. Payments for services will be due before an appointment will be made and this amount is non-refundable unless I provide 48 hours notice of cancellation. I further understand that if I habitually break appointments without 24 hour notice I could be terminated from the practice.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (”HIPPA”), I have certain rights to policy 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 acknowledge that I have received 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 health care 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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Policy Practices Acknowledgement, but was unable to do so as documented below:

DATE:	INITIALS:	REASON: