Kerzner Orthodontics, P.C. Disclosures

1. Please sign the Notice of Privacy Practices disclosure (HIPAA).

I, _____, have received a copy of this office's Notice of Privacy Practices.
Patient or Parent/Guardian if under 18 *(please print)*

_____
Patient Name *(please print)*

_____
Signature of Patient or Parent/Guardian if under 18

_____
Date

2. Please sign our Insurance Disclosure.

If you have orthodontic insurance, we will submit the appropriate insurance forms as a courtesy. It is your responsibility to provide our office with your insurance information and to advise us of any changes to your insurance coverage. Our office cannot bill your insurance without being supplied with the proper insurance information in a timely manner. Our office does not normally receive an EOB for each patient, therefore, if your insurance carrier, benefits and/or personal information changes, please notify our office as soon as possible. Insurance is billed monthly or quarterly depending on your group policy and all insurance payments and information should come directly to you. It is your responsibility to monitor your insurance. Our office is not responsible for any payments not received from your insurance. Failure to update any information could interfere with insurance reimbursement. If you have not received any payments from your insurance carrier in 30 days from starting treatment, please notify our office to resubmit any missing claims.

I HEARBY CERTIFY THAT ALL I HAVE READ AND RECEIVED A COPY OF THIS DISCLOSURE STATEMENT AND ALL QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I ACCEPT THE TERMS AND CONDITIONS SET FORTH IN THIS FINANCIAL AGREEMENT.

I, _____, acknowledge this office's Insurance Disclosure stated above.
Patient or Parent/Guardian if under 18 *(please print)*

_____
Patient Name *(please print)*

_____
Signature of Patient or Parent/Guardian if under 18

_____
Date

3. If you filled out the online Patient Information Form, please sign below to certify that the information you submitted is correct and accurate to the best of your knowledge.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental/orthodontic services I may need.

I, _____, acknowledge the above statement.
Patient or Parent/Guardian if under 18 *(please print)*

_____
Patient Name *(please print)*

_____
Signature of Patient or Parent/Guardian if under 18

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment 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):