**Little House Dentistry**

**Financial Agreement**

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

**Insured Patients:** The patient is responsible for estimated copayment on procedures and/or deductible at the time of services rendered. After insurance has responded, any unpaid amount will be billed directly to the patient.

**Non-Insured Patients:** Payment is due at the time of services rendered.

**Acknowledgement of Receipt of**

**HIPAA Notice of Privacy Practices**

**Please Note: It is your right to refuse to sign this acknowledgement**

I acknowledge that I have received a copy of this Dental Practice’s HIPAA Notice of Privacy Practices.

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Patient name (please print)

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Patient signature

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Date