Highland Dental
1555 E 12th Street
Casper, Wyoming 82601

Notice of Privacy Practices

Acknowledgment of Receipt

I acknowledge that I received a copy of Highland Dental Notice of Privacy Practices.

Patient's name: ___________________________________

Signature: _____________________________ Date: _______________

Payment Agreement

I, _________________________ as the person responsible for this account, agree to pay for all services rendered and /or goods sold to me or my ward immediately upon demand by Highland Dental LLC. I further agree that in the event of non-payment to Highland Dental LLC of any amounts due under this agreement I will pay interest thereon at the rate of 1.50% per month. I will pay all of Highland Dental, LLC. reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to a collection company. I will pay a collection fee of 35% of the unpaid balance due, which is in addition to the unpaid balance due under this agreement.

Signature of person responsible for this account:

please sign front and back

Highland Dental

Financial and Insurance Policy Consent

Name ________________________________ Date ____________________________

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for the dental services and materials not paid by my dental benefit plan, unless prohibited by law or the contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

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Patient, Parent/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me or subscriber of the policy, directly to Highland Dental, LLC.

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Patient, Parent/Guardian Signature Date

Cell Phones

I consent ______ / do not consent ______ to Highland Dental, LLC. Using my cell phone number to call or text regarding appointments and to call or leave a message regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone number is: (include area code) (_____)______________________________

____

Signature