To Our Valued Patient,

Thank you for choosing Central Park West Dental Studio as your dental provider. We Have a personal, professional and ethical responsibility to care for you health to the best of our abilities. Missed appointment and failure to comply with recommended treatment schedules and/or procedures prevent us from achieving our goal of optimum health for recommendations; we will not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. No-shows are not acceptable. Failure to make it to an appointment not only compromises your health but also inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep an appointment, you are expected to call **48 hours before** your appointment to reschedule. Otherwise there is **a $150.00 broken appointment fee** that is not covered by your insurance.
2. Timeliness is required. We will see you on time and get you out on time, unless there is an emergency. We request that you be on time for your visits.
3. If you miss an appointment you must make it up. It is critical to your health to do so to avoid set backs in the care and maintenance of your teeth and gums.
4. Insurance: Treatment recommendations are based on health, not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being, we are. We will provide you with an estimate of benefits; however, you are fully responsible for your treatment. Your benefits are a contract between you and your insurance company. We are not responsible for what your insurance will or will not cover.
5. We run a ZERO balance office; therefore all financial aspects of your treatment will be discussed prior to the beginning of treatment. Any and all co-pays and/or deductibles must be made at the time treatment is rendered. All patients are expected to comply with their financial agreements with this office. Any insurance balance not received after 90 days will become your responsibility.
6. I acknowledge that I have read and received a copy of this office's Notice of Privacy Practices HIPAA (Health Insurance Portability and Accountability Act.)
7. All payments are due at the time of services with credit card on file (if other arrangements are not made). If after 90 Days from the time of services the balance is not paid agree to allow the credit card on file to be charged.

We greatly appreciate your cooperation, and keep in mind that any miscommunication you should encounter, please make us aware immediately, so we may give it the proper attention for an effective resolution.

Central Park West Dental Studio

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Patient

Central Park West Dental Studio
350 Central Park West suite #1E
New York, NY 10025
(212)678-1144

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, ________________________________, have reviewed a copy of this office's Notice of Privacy Practice.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

ڤ **Individual refused to sign**

ڤ **Communications barriers prohibited obtaining the acknowledgement**

ڤ **An emergency situation prevented us from obtaining acknowledgement**

ڤ **Other (Please Specify)**

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