

RIZZO DENTAL GROUP
6150 Metrowest Blvd. Suite 207
Orlando, FL 32835
407-521-8765

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

OFFICE POLICIES:

Regarding Insurance: Your insurance policy is a contract between you and your insurance company. You are responsible for what diagnosis and/or procedure(s) may or may not be considered for payment. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, “usual and customary” charges, etc., other than to supply factual information.

We will gladly process your claim but we request that you pay your estimated portion **when services are rendered**. You are responsible for any charges not paid by your insurance company.

Patient Initial _____

Payment Policy: Payment for dental treatment is expected in full the day service is rendered. Any payment options must be arranged and in writing prior to any treatment. Payment plans are available through **Care Credit** upon credit approval.

Patient Initial _____

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BROKEN APPOINTMENT POLICY:

If you are unable to keep your appointment kindly give the office a 24 hour notice. We reserve the right to **charge a fee for all broken appointments without a 24hour notice.**

It is the patient's responsibility to inform the office of any changes in their address and contact numbers.

Please be aware that the appointment reminder call is a **courtesy** extended by our office to the patient.

RELEASE OF SIGNATURE FOR INSURANCE / SIGNATURE ON FILE:

I agree to be responsible for all charges for the dental services and materials not paid by my dental benefit plan. I hereby authorize payment of the dental benefits otherwise payable to me directly to the named dental entity.

Patient's Signature (or parent of minor)

Date