COSTA LOWRY DAGEENAKIS FAMILY DENTISTRY

Please Initial and Sign:

____ As a courtesy to our patients using insurance; we are happy to file claims. All benefits quoted are **estimates** only and not a guarantee of payment from your insurance. If you have any questions regarding your coverage, please contact your insurance company.
____ If insurance coverage is terminated or has not been updated with Costa, Lowry & Dageenakis Family Dentistry the patient will be responsible for all incurred charges.
____ Treatment plans and associated fees may change without notice if it's in the best interest of the patient at the time of treatment.
____ All estimated fees are due at time of treatment. We are happy to discuss finance options. We gladly accept Visa, Master Card and Discover. Also ask us about Care Credit.
____ In the event of a "No Show" for a scheduled appointment without 48 hour notice a charge of $75 will be billed to the patient.

Additional Disclosure Authority

In addition to the allowable disclosure described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information of the persons indicated below. My signature confirms that I have been offered a copy of the Notice of Privacy Practices for Costa, Lowry & Dageenakis Family Dentistry.
The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is available at any time to read.
Dr. Marta Costa D.D.S., Dr. Miranda Lowry D.D.S. and Dr. Michael Dageenakis D.D.S. reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my visit after revisions become effective.

- ANY MEMBER OF MY IMMEDIATE FAMILY Yes No
- SPOUSE ONLY Yes No
- OTHER (please specify) _____ Yes No

I have read and understand the above information. I acknowledge that I am ultimately responsible for all services rendered by Dr. Marta Costa, Dr. Miranda Lowry and Dr. Michael Dageenakis.

Signature: _____ Date: _____