

# Acknowledgements

## Release of Information to Insurers and Assignment of Benefits

To the extent permitted by law, I consent to Better Dental's use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Better Dental of the dental benefits otherwise payable to me.

I agree: Yes/No

## Payment and Refund Policy

In all cases, Better Dental patients agree to the following payment policies: Payment in full of the estimated patient portion of the fees is due no later than when services are rendered.

For comprehensive treatment plans requiring multiple office visits, Better Dental requires a minimum deposit of 50% of the total estimated patient portion of the fees at the start of treatment.

Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law, or unless Better Dental has a contractual agreement with my plan prohibiting all or a portion of such charges.

Patients may, at their discretion, elect to pay in full, in advance for comprehensive treatment plans.

You may discontinue treatment and request a refund from Better Dental at any time. Better Dental will refund any amount paid for treatment that you did not receive. All Refunds will be processed back to the original form of payment, except cash payments will be refunded by check.

I agree: Yes/No

## Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have read Better Dental's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I agree: Yes/No