Nicole M. Stevens, DDS, PLLC
1395 N. Courtenay Parkway, Suite 105 Merritt Island, FL 32953
(321) 453-4746 – phone (321) 453-5140 - fax

PATIENT AUTHORIZATION & APPOINTMENT POLICIES

- In accordance with HIPAA federal legislation, I consent to the use and disclosure of my or my dependent's Protected Health Information by Nicole M. Stevens, DDS, PLLC to carry out treatment, payment activities, and healthcare operations. ___________
  Initial
- Treatment information, payment activities, and healthcare operations may be disclosed to a spouse, a parent, a guardian, or caregiver unless specifically declined in writing. ____________
  Initial
- I acknowledge that payment for services is due at the time of treatment and that I am financially responsible for all charges for myself or dependents whether or not paid by my dental benefit provider. **Finance charges will accrue on all accounts 60 days past due and I understand that I am financially responsible for all charges incurred to collect debt (i.e. collection fees, finance charges, etc.)**__________
  Initial
- FOR PATIENTS WITH INSURANCE: I assign all payments from my dental benefit provider for services rendered to be paid directly to Nicole M. Stevens, D.D.S., PLLC. I authorize the use of my signature below on all dental benefit submissions, whether manual or electronic. ________
  Initial
- If completing this form for a minor dependent, I authorize the dentist and/or staff members to perform dental services for my child/dependent which are deemed necessary by Nicole M. Stevens, D.D.S., PLLC.__________
  Initial
- I understand that a minimum of 24 business hours notice is required for cancellation of any appointment. **Failure to provide adequate notice may result in a minimum charge of $50.00**. ***Appointments reserved for 1 ½ hours or longer will be charged according to procedure type and can be up to $150.00***. Also, if we are unable to confirm with you 24 hrs prior to your appointment, it may be given to another patient._________
  Initial
- I acknowledge that I have been provided the opportunity to read, review, and/or obtain a copy of the Notice of Privacy Practices for Nicole M. Stevens, D.D.S., PLLC._____________
  Initial
- I acknowledge that I have been provided with a copy of Practice Policies for Nicole M. Stevens, D.D.S., PLLC, I have read and accept the policies as stated. ____________
  Initial
- I consent to the use of dental photographs for treatment planning, identification, and treatment communication with dental laboratories, third-party payers and other dental or medical healthcare providers.___________
  Initial

I, _____________________, have read, understand and accept the authorizations and policies explained above.
(Print Name)

____ ___________________________
Signature Date