



2182 Sandy Drive Suite 102, State College, PA 16803  
814-234-4444  
Fax: 814-954-5652  
Email: [info@dentistrybyaprilnetar.com](mailto:info@dentistrybyaprilnetar.com)

Dear Patient,

On behalf of Dr. Detar, Dr. Fisher, and the entire staff here at Dentistry by April Detar, welcome to our office! We very much look forward to serving all your family's dental needs for many years to come. We appreciate the trust you have placed in us, and we will strive to provide the high quality of dental care that you expect.

Our mission is to be the best office for comprehensive dental health in State College, PA, giving our patients exclusive attention with the doctor, hygienist, and team, always striving to foster patient relationships based on mutual trust. We dedicate ourselves to staying on the cutting edge of technology and dentistry by continually attending higher educational classes at the world's most premier post-dental education institutes for advanced learning, allowing us to offer our patients not only general dentistry, but also specialty services in the comfort of our own dental chairs.

Our team is devoted to making your appointments as pleasant and enjoyable as possible. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires. The first step toward complete oral health is a thorough examination and diagnosis. We want our patients to make informed choices by fully understanding any problems. Dr. Detar or Dr. Fisher will review your dental needs with you at this appointment or have you return for a second appointment to provide treatment consultation.

We will make every effort to ensure your dental care is affordable. It is the patient's responsibility to provide payment in full at the time of service unless other financial arrangements have been arranged. For your convenience, we accept Visa, Mastercard, Discover, and American Express. If you have dental insurance, please provide your dental insurance information prior to your initial visit. We will work with you to assure that you receive the maximum benefits to which you are entitled. For those that do not have insurance, we offer an in-house Dental Care Membership Program.

We look forward to meeting you! Feel free to ask questions of our staff. We are all here to help you.

Thank you again for choosing our dental practice.

Sincerely,  
April A. Detar DMD  
Bailey Fisher DMD



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Email: info@dentistrybyaprildetar.com

PATIENT INFORMATION:

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How were you referred to our office?

\_\_\_\_\_

SPOUSE INFORMATION:

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Work \_\_\_\_\_

Social Security Number: \_\_\_\_\_

The confidential information requested is important for your treatment and insurance claim. If there is anything else we need to know, please tell us.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ City/State: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

**List all medications that you are now taking:**

_____	_____
_____	_____
_____	_____
_____	_____

**Are you allergic to any of the following?**

- |                                       |   |                                       |
|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Acrylic      | <input type="checkbox"/> Iodine                     | <input type="checkbox"/> Sulfa Drugs  |
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Latex                      | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Local Anesthetics (Dental) | <input type="checkbox"/> Tylenol      |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals or Jewelry          |                                       |
| <input type="checkbox"/> Ibuprofen    | <input type="checkbox"/> Penicillin                 |                                       |

**Do you have any of the following medical conditions?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acid Reflux (GERD)            | <input type="checkbox"/> Difficulty Breathing/ Easily Winded |  |
| <input type="checkbox"/> AIDS/HIV Positive             | <input type="checkbox"/> Emphysema                           |  |
| <input type="checkbox"/> Alzheimer's Disease           | <input type="checkbox"/> Enlarged Lymph Nodes                | <input type="checkbox"/> Mitral Valve Prolapse       |
| <input type="checkbox"/> Anaphylaxis                   | <input type="checkbox"/> Epilepsy or Seizures                | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Fainting/ Dizziness                 | <input type="checkbox"/> Pacemaker                   |
| <input type="checkbox"/> Angina                        | <input type="checkbox"/> Glaucoma                            | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Arthritis/Gout                | <input type="checkbox"/> Hay Fever                           | <input type="checkbox"/> Psychiatric Treatment       |
| <input type="checkbox"/> Artificial Heart Valve        | <input type="checkbox"/> Headaches (frequent)                | <input type="checkbox"/> Radiation Treatment         |
| <input type="checkbox"/> Artificial Joint              | <input type="checkbox"/> Heart Attack                        | <input type="checkbox"/> Respiratory Disease         |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Heart Murmur                        | <input type="checkbox"/> Renal Dialysis              |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Heart Surgery                       | <input type="checkbox"/> Rheumatic Fever             |
| <input type="checkbox"/> Bacterial Endocarditis        | <input type="checkbox"/> Hepatitis A                         | <input type="checkbox"/> Rheumatism                  |
| <input type="checkbox"/> Bleeding (Abnormal/Excessive) | <input type="checkbox"/> Hepatitis B or C                    | <input type="checkbox"/> Scarlet Fever               |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Hemophilia                          | <input type="checkbox"/> Shingles                    |
| <input type="checkbox"/> Blood Transfusion             | <input type="checkbox"/> Herpes                              | <input type="checkbox"/> Sickle Cell Disease         |
| <input type="checkbox"/> Breathing Problems            | <input type="checkbox"/> High Blood Pressure                 | <input type="checkbox"/> Sinus Trouble               |
| <input type="checkbox"/> Bruise Easily                 | <input type="checkbox"/> High Cholesterol                    | <input type="checkbox"/> Slow Healing Mouth Wounds   |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Hives or Rash                       | <input type="checkbox"/> Spina Bifida                |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Hypoglycemia                        | <input type="checkbox"/> Stomach/Intestinal Disorder |
| <input type="checkbox"/> Chest Pain (Angina Pectoris)  | <input type="checkbox"/> Irregular Heartbeat                 | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/> Jaundice                            | <input type="checkbox"/> Swelling of Limbs           |
| <input type="checkbox"/> Colitis                       | <input type="checkbox"/> Jaw Pain                            | <input type="checkbox"/> Thyroid Disease             |
| <input type="checkbox"/> Cold Sores (Herpetic Lesions) | <input type="checkbox"/> Kidney Problems (Renal Disease)     | <input type="checkbox"/> Tonsillitis                 |
| <input type="checkbox"/> Congenital Heart Defect       | <input type="checkbox"/> Leukemia                            | <input type="checkbox"/> Tobacco or Vape Use         |
| <input type="checkbox"/> Cortisone Treatment/Medicine  | <input type="checkbox"/> Liver Disease                       | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Cough (Persistent/Body)       | <input type="checkbox"/> Low Blood Pressure                  | <input type="checkbox"/> Tumors (Head/Neck)          |
| <input type="checkbox"/> Diabetes Type I               | <input type="checkbox"/> Lyme Disease                        | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Diabetes Type II              | <input type="checkbox"/> Migraines                           | <input type="checkbox"/> Venereal Infection          |
|  |  | <input type="checkbox"/> Weight Loss (unexplained)   |

**HOSPITALIZATIONS & SURGERIES**

Have you ever been hospitalized or had ANY surgical operations?

Yes

No

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**ALCOHOL & SUBSTANCES**

	Yes	No
Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an alcohol dependency?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been, or are currently, under treatment for chemical dependency or substance use disorder?	<input type="checkbox"/>	<input type="checkbox"/>

**WOMEN: Are you**

	Yes	No
Pregnant/ Trying to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Taking oral contraceptive or have a contraceptive implant	<input type="checkbox"/>	<input type="checkbox"/>

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Signature

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Today's Date

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU** We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends, or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials who have lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**SUD Treatment Information.** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

**OTHER USES AND DISCLOSURES OF PHI** Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

#### **YOUR HEALTH INFORMATION RIGHTS**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** Except for certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this account more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information

pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**QUESTIONS AND COMPLAINTS** If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:**

Privacy Official Name: Dentistry by April Detar

Telephone: (814)234-4444 Fax: (814)954-5652

Address: 2182 Sandy Drive Ste 102, State College, PA 16803

Email: info@dentistrybyaprildetar.com



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# HIPAA

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

### PERMISSION TO DISCUSS DENTAL TREATMENT

If you may want a family member or friend to discuss your dental treatment with our office, we must have in writing permission/consent from you to do so. Please list any person you give Dentistry by April Detar, LLC permission/consent to discuss your dental treatment with:

**\*\* If the patient is a minor, we will discuss dental treatment with either parent or guardian\*\***

Please select one of the following below:

\_\_\_\_\_ I hereby give permission/consent to Dentistry by April Detar, LLC to discuss all dental treatment with the following individuals:

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\_\_\_\_\_ I do not wish Dentistry by April Detar, LLC to discuss any of my dental treatment with anyone other than me.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## PATIENT CONTACT PREFERENCE

Please indicate all ways in which you would prefer to be contacted by our office:

- Home Phone: \_\_\_\_\_  
\_\_\_\_ Voicemail with detailed information.  
\_\_\_\_ Voicemail with call back number only.
- Cell Phone: \_\_\_\_\_  
\_\_\_\_ Voicemail with detailed information.  
\_\_\_\_ Voicemail with call back number only.
- Work Phone: \_\_\_\_\_  
\_\_\_\_ Voicemail with detailed information.  
\_\_\_\_ Voicemail with call back number only.
- Written Correspondence  
\_\_\_\_ Mail information to my home address.  
\_\_\_\_ Mail information to my work/office address.  
\_\_\_\_ Max information to this number \_\_\_\_\_  
\_\_\_\_ E-mail information to this e-mail address \_\_\_\_\_
- Text Message  
\_\_\_\_ Text with detailed information.  
\_\_\_\_ Text with call back number only.
- Other \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name / Relationship (If minor) \_\_\_\_\_

DENTISTRY BY APRIL DETAR  
**SIGNATURE ON FILE**

- I AUTHORIZE USE OF THIS FORM ON **ALL** MY INSURANCE SUBMISSIONS.
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- I UNDERSTAND THAT **I AM RESPONSIBLE** FOR MY DENTAL BILL.
- I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES.
- I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- MY SIGNATURE ALSO APPLIES TO ALL DEPENDENTS LISTED ON MY INSURANCE PLAN.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



## Financial Policies and Release of Information

Thank you for choosing Dentistry by April Detar for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist in cost of dental care.

As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us accurate and up-to-date insurance information.

Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made. We accept Cash, Check, Debit Cards, Visa, MasterCard, and Wells Fargo. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days. Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all cost before treatment is administered. If special arrangements are needed, please talk to our financial manager prior to receiving service.

Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year. If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

**Missed Appointments:** Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment, please notify us (even after hours) at least 24 hours in advance. Failure to notify us less than 24 hours before your appointment may result in a minimum broken appointment charge of \$75.00.

**Returned Checks:** For checks returned to us, as unpaid by your bank, we will charge you a \$35.00 fee.

**Past Due Accounts:** Overdue accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection; you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform Dentistry by April Detar of any changes associated with my insurance status. I agree to make an in-full, prompt payment to Dentistry by April Detar when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to Dentistry by April Detar.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

Dentistry by April Detar has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_