Dubuque Dental Associates
Dr. Brett Kilburg
Dr. Melanie Stuntz

Patient Consent Form/Office Policy

FINANCIAL RESPONSIBILITY

☑ I understand and agree that with or without insurance I am responsible for my balance. My balance is to be paid 28 (twenty-eight) days from receiving my state ment from Dubuque Dental Associates.
Non-payment on my account will lead to collections through an agency or small claims court.

☑ I understand that my insurance is billed by Dubuque Dental as a courtesy.

☑ Payments can be made to Dubuque Dental by cash, personal check, Visa, Master-card, Care Credit or Flex Spending cards.

Signature _____ Date _____

CANCELATION AND NO-SHOW POLICY

Dubuque Dental Associates considers canceling your appointment or not showing up for scheduled appointment time to be a serious issue. Your health and well-being is important to us. When Dubuque Dental schedules appointment time for you it is reserved for you. Therefore, we request a 24 hour advance cancellation notice. (Emergency situations excluded.)

If you fail to arrive for your allotted appointment time there may be a **$25 relinquished appointment fee** attached to your next statement. This is not a service fee covered by insurance and must be paid by the patient, prior to any rescheduling.

I have read the above and agree to this policy.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICE (HIPPA)

I acknowledge that I have been offered a copy of the Dubuque Dental Associates Notice of Privacy Practices (HIPPA).

Signature _____ Date _____