Philip H Schwenk, D.D.S
1444 Executive Blvd.
Jasper, IN 47546
(812) 481-2121

Office Financial Policy:

This office requires payment of your deductible and co-payment at the time of service. You will be notified of any amount not covered by insurance. The balance will be due and payable upon receipt of a statement. I accept full financial responsibility for all treatment performed by the doctors and dental staff. I will be responsible for all fees for service rendered. Fees of $25.00 will be charged per returned check. Insurance coverage is a contractual arrangement between myself and the insurance company only. A collection fee in the amount of $45.00 will be added to each account balance that is past due and is turned over to a collection agency or law firm for collection. By signing below, I agree to be financially responsible for all costs of collection, including reasonable attorney fees and court costs.

Acknowledgement of Notice of Privacy Practices (HIPPA):

Copies of this document is provided both on the web and at the office of Dr. Philip H Schwenk, D.D.S. Our website is: www.schwenkdfamilydentistry.com

Consent for Service:

I herby give permission to the dental practice of Dr. Philip H. Schwenk, D.D.S., to render all necessary services to facilitate treatment for myself, or the child or children named on this form. Furthermore, I will be responsible for any professional fee incurred on my behalf or the child or children treatment.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to a third party payers and/or other health practitioners. I grant my permission to you or your assignee to leave confidential information on my home phone or cell phone voicemail if the doctor and/or staff is unable to reach me directly to facilitate the communication of an appointment or other confidential information. If unable to reach me or leave results on my voicemail, I also authorize Philip H Schwenk DDS, PC to leave confidential information with my spouse/partner directly or on my spouse/partner's home phone or cell phone voicemail.

By signing this document, I agree to the office financial policy, consent for service, and **acknowledgement of notice of privacy practices (HIPPA).**

Date: _____ Patient Name & Date of Birth: _____

Responsible Party Signature: _____