Personal Information Privacy Act and Payment Agreement

We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner and disclose personal information when permitted or required by law.

Personal Information Procedures

We collect contact, medical and financial information about our patients such as names, home/work addresses, home/work phone numbers, e-mail addresses, date of birth, insurance plan details, health/dental histories, emergency contact information.

* Contact information is disclosed to health benefit providers and insurance companies, with the consent of the patient, for purposes of submission of claims, for reimbursement or payment of dental care, predetermination of dental treatment, open and update patient files, invoice patients for dental services, process dental claims, and to send reminders to patients concerning the need for further dental treatment.

* Medical information is disclosed, with consent of the patient, to other dentists, dental specialists, or health care professionals such as physicians. It is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

* Financial information is collected for payment processing purposes. It is not shared with third parties unless permitted by law for outstanding bill collection purposes

Consent for Email, Text, Social Media Communication

To comply with the Canadian Anti-Spam Legislation (CASL) that is in effect as of July 1, 2014, our dental office would like to have your express consent to continue communicating with you and providing you with important information

from us. We are committed to never sending spam emails and our privacy policy will always protect your electronic information.

INSURANCE AUTHORIZATION (IF APPLICABLE)

I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I understand that I am personally responsible for payment and it is my responsibility to insure that reimbursement is received from my insurance company. As a courtesy Dr. Nadia Filice Dentistry Professional Corporation offers the option of accepting payment directly from insurance, however ultimately my account is my responsibility. I authorize the release of information contained in claims to my insuring company/plan administrator and in claims submitted electronically.

FINANICAL AGREEMENT

In consideration for services rendered by Dr. Nadia Filice Dentistry Professional Corporation, I guarantee prompt payment for services at the time they are provided. If Dr. Nadia Filice Dentistry Professional Corporation does not receive payment within 30 (thirty) days from the date such balance is due, the bill may be turned over to a collections agency and if so, I agree to pay all reasonable costs including collection fees.

I have read all of the above statements and accept the terms and conditions. I consent to electronic communication and to the collection, use and disclosure of my personal information and that of my dependents (if applicable).

Signature:__________

Date:_____________