Great Lakes Oral & Maxillofacial Surgery, P.C.
Dr. R. Scott Sheperd
Dr. Sean J. Stringer
405 N. Division Rd.
Petoskey, MI 49770

Please be advised, we do not participate with insurances. Payment for services is expected in full on the date of service.

We accept cash, Visa, MasterCard, Discover, American Express, and CareCredit as forms of payment. We do not accept checks or offer any in-house financing (payment plan). We will be happy to file your dental claim on your behalf, and the insurance company will reimburse you directly.

We require a minimum of 24 hours notice to cancel or reschedule an appointment. Failure to do so will result in a $100 fee, minimum of 3 months wait to be rescheduled, and potential deposits for any future services.

Please sign below to indicate you have read and understand the above statements. Thank you for your cooperation.

Date__________________ Signature__________________________________

Print Name____

Notice of Privacy Practices

And

Consent for Use and Disclosure of Health Information

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will use in the future.

To comply with one of HIPAA's requirements, a copy of our Notice of Privacy Practices can be provided to you upon your request. This notice contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement as discussed above) us to obtain your written consent prior to disclosing any of your information except our disclosures in connection with: a defense to a claim challenging our profession competence; a review entity's functions: a claim for payment of fees; a third party payer's examination of our records; a court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation

It may be necessary for us to make disclosures of your information in connection with your treatment. An example: we may make a referral to or consult with another dentist or healthcare professional, provide a specimen to a laboratory for testing, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient acknowledgement and consent

Please sign this form below to consent to our disclosures of your information that we deem necessary to provide you with proper treatment.

Date________________ Signature______________________________

Print Name____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)____
- Office personnel (signanture)__________________________ Date_________