Daniel P. Weyrauch, D.D.S.
1075 Featherstone Road – Rockford, IL 61107
815-399-4379

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

INSURANCE AGREEMENT

Patient Name: _____

I understand that my insurance will only pay a portion of my treatment (according to their plans and provisions). I am responsible for any balance(s) not paid by my insurance company.

I understand that Dr. Daniel P. Weyrauch will file the claim with my insurance company. If there are any denials and/or benefits are not paid, it is my responsibility to call the insurance company and discuss any issues with them.

I understand that if I receive any benefit payment from the insurance company I am responsible for any outstanding balance I have with Daniel P. Weyrauch. After which, I will make payment in full at time of service and have the insurance company reimburse me for all other treatment.

I understand that Dr. Daniel P. Weyrauch is not responsible for submitting any outstanding claims and/or collecting any benefit payment(s) owed by the insurance company after forty-five (45) days from the first claim submission and/or date of service.

_____ _____
Patient Signature Date

FINANCIAL RESPONSIBILITY

The undersigned hereby states that he/she is the patient and/or financially responsible party and is personally liable for and/or personally guarantees all amounts due to Dr. Daniel P. Weyrauch, including service charges. This obligation and/or personal guarantee shall remain in force and effective as long as there is any amount due for professional services extended to the patient and/or financially responsible party.

The undersigned agrees and guarantees that, in the event of default in payments when due, that he/she will pay, in addition to all sums due, all costs of collection, including attorney's fees and courts costs and all collection agency fees, not to exceed 50%, incurred by Dr. Daniel P. Weyrauch.

The undersigned agrees to pay a service charge of 1 ½ % per month or 18% annually for all invoices or statements of account not paid within 90 days.

_____ _____
Patient Signature Date