NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices. A copy of this signed and dated Acknowledgement shall be as effective as the original.

Patient Name

Relationship to Patient

Signature

Date

PATIENT CONSENT FORM

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations; of the uses and disclosures we may make of your protected health information; and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment, or healthcare operations. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this
Consent form and your Notice of Privacy Policies. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Name

Relationship to Patient

Signature

Date

FINANCIAL POLICY

Our office wants all our patients to be able to comfortably afford dental care, so we are offering the following payment options. Please read through this form and sign at the bottom.

Full payment is due at the time of service. Failure to render payment for services within a timely manner could result in the discontinuation of future treatment.

Payment Options:
- We accept cash, check, Visa Mastercard, Discover, and American Express.
- We do accept assignment of insurance benefits, but estimated copay and deductible will be due at time of service.
- If your treatment requires extended time, a deposit will be required and subsequent payments will be due on specific dates.
- If your treatment has an out-of-pocket expense of $1,000.00 or more, we do offer a 5% bookkeeping discount if you pay the total in advance by cash, check, or money order.
- We do offer an extended payment plan through outside financing companies.

Regarding Insurance Assignment:
We will submit claims to your insurance company on your behalf. However, this balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all necessary insurance information. Your insurance policy is a contract between you and your insurance. We are not a party to that contract. The estimate provided by this office is considered a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. Claims are submitted promptly after treatment is rendered and, if not paid by the patient's insurance company by the 61st day after treatment, will be billed in full to the patient.

Finance Charge:
A finance charge will be imposed on each item of our account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at the rate of 1.5% per month or an annual percentage rate of 18%. The finance charge on our account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $0.50.

Monthly Statements:
If you have a balance on your account, we will send a statement. It will show separately the previous balance, any new chang es to the account, the finance charge, and any payments or credits applied to your account during the month. Please note we will only hold the balance for up to 60 days before the account is transferred to a collection agency.

Past Due Accounts:
If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all collections costs incurred, including lawyer fees and court cost if taken to court.

Waiver of Confidentiality:
You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in cou rt, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become public record.

Returned Checks:
There is a fee (currently $25.00) for any check returned by the bank.

Missed Appointments:
Once an appointment has been made, please remember this time has been specifically reserved for you. If you need to reschedule or cancel an appointment, we request 24 hours' notice. We do understand that unexpected emergencies may arise not allowing for 24 hours' notice; thus, we request notice as soon as possible. Please note we do reserve the right to charge a missed appointment fee of $50.00. More than two missed or broken appointments may result in the discontinuation of further treatment.

Transferring of Records:
You will need to sign a release of information form and pay a copying fee (currently $15.00) if you would like to have copies of your records sent to another office.

Worker’s Compensation:
We require written approval/authorization by your employer and/or worker’s compensation carrier prior to your initial visit. If the claim is denied, you will be responsible for payment in full.

Personal Injury:
If you are being treated as part of a personal injury lawsuit or claim, we require verificat ion from your attorney prior to your initial visit. We also require that you allow us to bill your insurance; if there is no insurance, other financial arrangements may be discussed. Payment for services rendered remains the patient’s responsibility; we cannot bill your attorney for charges incurred due to a personal injury case.

Divorce:
In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsi ble for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Co-Signature:
If another person signs this or another financial policy, that co -signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Financial Consent:
Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name

Relationship to Patient

Signature

Date