SHORT PUMP
FAMILY DENTISTRY

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

· Protected health information may be disclosed or used for treatment, payment or health care operations
· The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
· The Practice reserves the right to change the Notice of Privacy Policy.
· The patient has the right to restrict the use of their information.
· The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
· The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

This HIPAA Consent/Sharing was signed by (Signature) (Today's date)

_____

Relationship to patient (if other than patient)

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OFFICE GUIDELINES

Guarantor: Please review our financial conditions. By signing below, you agree to be bound by these terms.

Balances on all accounts are due at the time of service, unless other arrangements have been made. Account information such as mailing address, emergency, contact phone number, must be kept up to date. Identification and insurance card may be asked for at each visit, policy holder's or guarantor's date of birth and social security number are required for account verification.

Cancellation Guideline: If you find that you are unable to make your reserved appointment, we require **a 24 hour notice**. **There will be a $40 fee assessed for every missed appointment without 24 hour notification.** We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first offense. However, we reserve the right to terminate any patients after 3 late cancellations or no-show appointments.

Financial Obligation/Payment Guidelines

Patients with dental benefits: As a courtesy to our patients who have dental benefits, we are happy to file your claims electronically from our office. Please understand that it is your responsibility to know your specific plan/policy coverage. Your dental benefits may cover more or less than we estimate. Your existing insurance coverage will require payment in full at the time services are rendered or immediately upon notice of insurance claim denial. You will be responsible for communicating with your carrier regarding denied services.

Patients without dental benefits: Patients without dental benefits are required to pay in full at the time services are rendered.

Patients with a Quality Dental Plan (QDP) membership, offered in-office only, are required to pay in full at the time services are rendered.

Payment Plan Options Short Pump Family Dentistry offers payment plan options through Care Credit. Care Credit offers interest free payment options along with extended payment plans. Log on to www.carecredit.com for more information. Brochures available upon request. If you have any questions, please do not hesitate to ask.

Returned Checks: Checks returned to us by your bank will be assessed a **bank return check fee of $40.00.**

Unpaid Balances: Sums due hereunder are payable at the practice office. If balances are not paid according to the terms, then the account will be considered past due. If patients account becomes more than thirty(30) days past due, guarantor agrees to pay a finance charge of one and one half percent (1.5) per month, eighteen percent (18) annum. It is further understood and agreed that if this account or any debt owed to practice is referred to a collection agency or attorney, guarantor agrees to pay, in addition to the balance of account (which includes but is not limited to, principle, accrued interest, and late charges), all collection fees in the amount of forty percent (40) of the total unpaid balance due, plus court costs and filing fees incurred by practice. Guarantor agrees to pay the aforesaid costs of collection whether or not suit is filed. Guarantor further understands and agrees that should practice be awarded judgment relating to this contract or any debt incurred thereof, guarantor will pay judgment interest of one and one half percent(1.5) per month, eighteen percent (18) annum, beginning on the date of the judgment. A photocopy of this contract shall be considered as valid as the original.

Consent to treat and release medical/dental information: I hereby assign all dental and or surgical benefits, to include dental benefits to which I am entitled, private insurance, and any other health plans to the rendering physician. I authorize said assignee to release all information necessary to satisfy national healthcare and quality standards as well as secure payment for services rendered. I also understand that I am responsible for all charges (including non-covered charges) arising from the treatment of the above name patient. I certify that the demographic information provided on the registration form is true to the best of my knowledge. I have read, understood and agree to be bound by terms of this financial policy. This signature is valid until notification in writing is received.

_____ _____

Signature of patient or guardian Date