

An Elegant Smile

COMPREHENSIVE
FAMILY & SPECIALTY DENTISTRY

FINANCIAL POLICY

- I understand it is my responsibility to pay for all dental treatment provided in this office for my dependents and myself at the time of services, unless prior written arrangements have been made. In the event that payment is not received on the agreed upon dates, I understand that a 2% finance charge (24% APR) will be added to my account.
- I understand that my insurance coverage is a contract between my insurance company and myself. Not all services are a covered benefit.
- I understand that filing insurance claims is a courtesy that An Elegant Smile extends to all their patients and there are no guarantees of any estimated coverage's or payments.
- I understand that An Elegant Smile accepts cash, all major credit cards, personal checks, and financing from Care Credit.
- I understand that a \$35.00 Non-sufficient Funds Fee will be added to my account if a returned check is received from my bank.
- I understand that in the event my account needed to be assigned to an outside collection agency, a 30% collection fee based on the balance will be added.
- I understand that a \$25.00 Broken Appointment Fee or more may be added to my account if I fail to provide at least one business day's notice for cancelled or rescheduled dental services.
- I understand that it is my responsibility to advise the office of any changes in the information regarding my patient information, insurance and health history.
- I understand that a \$25.00 fee may be applied to my account for duplication of my dental records and x-rays.

Signature: _____ Date: ____/____/____

Relationship: _____

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Who Owns The Dental Record?

ARIZONA STATE BOARD OF DENTAL EXAMINERS
ARIZONA REVISED STATUTES
§32-1264 MAINTENANCE OF RECORDS

D. On a patient's request, that patient's dentist, dental hygienist or denturist shall transfer legible and diagnostic quality copies of that patient's records to another licensee or certificate holder or that patient. The patient may be charged for the reasonable costs of copying and forwarding these records.

What about my x-rays?

X-rays taken are the property of An Elegant Smile Dentistry and retained on the same theory as the patient's medical history record. Under legal test, the court ruled: "the x-ray plate becomes the veritable foundation stone of the doctor's diagnosis and report and it is essential that he retain it as a permanent record in support of diagnosis, for should it be destroyed by unskillful handling or loss, the doctor would have no means to justify the correctness of his diagnosis or findings in the event of challenge to his professional opinions."

Paraphrased from "Law of the Hospital, Etc., Hayt and Goreschell"

The original dental record, including but not limited to treatment notes, x-rays, lab slips, study models are the property of An Elegant Smile Dentistry. These originals will not be released to patients or other health care providers. Upon written request, a duplicate of a patient's dental record will be reproduced for a fee.

PLEASE NOTE:

AN ELEGANT SMILE DENTISTRY CHARGES \$ 25.00 PER DENTAL RECORD FOR DUPLICATION.

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ Date: ____/____/____

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An Elegant Smile Dentistry HIPAA Consent to Use Protected Health Information For Treatment, Payment and Healthcare Operations

I consent to allow An Elegant Smile Dentistry to use and disclose my protected health information for treatment, payment and health care operations.

Treatment means the provision, coordination, or management of healthcare and related services by one or more healthcare providers.

Payment means the activities undertaken by a healthcare provider or health plan to obtain or provide insurance reimbursement for the provision of health care.

Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; underwriting, premium rating and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of An Elegant Smile Dentistry.

I consent to allow An Elegant Smile Dentistry to disclose protected health information for treatment activities of another healthcare provider.

I consent to allow An Elegant Smile Dentistry to disclose protected healthcare information to another Elegant Smile Dentistry or provider for health care operations activities, provided that An Elegant Smile Dentistry and the other healthcare provider has or had a relationship with the below named patient. The disclosure must be for treatment or other health care operations or for the purpose of health care fraud and abuse detection or compliance.

Name of Patient _____

Signature of Person Authorizing Consent _____

Relationship to Patient _____

For Official Use

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 acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while in effect. This notice takes effect (9/28/2006), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

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)

Date: ____/____/____

(Signature)

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (please specify)
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