Office Policies

Notice of Privacy Practices & HIPAA

A laminated copy of our office Notice of Privacy Practices and HIPAA is available in our office. You have the right to read our Notice 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. We encourage you to read it carefully and completely before signing this consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from Third party payers, and the standard healthcare operations. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends, we will not be able to release any information to anyone other than the patient.

I hereby authorize Dentistry For You doing business as South Phoenix Dentist to release my patient health information as described below:

Authorized Individual Name	Relationship
Type of Information allowed to Disclose:	**Type of Disclosure**:
☐ Dental Records ☐ Financial	☐ Phone ☐ Person ☐ Email

I understand that I am not required to sign this authorization. I acknowledge that I have read or received a copy of this office's Notice of Privacy Practices and that Dentistry For You doing business as South Phoenix Dentist abides by the HIPAA Law and will protect the privacy of my personal information.

Patient Name (Print)	Signature or Patient or Guardian	Date

Authorization for Signature on File

I (name of patient), _____ and/or (name of insured) _____, hereby authorize Dentistry For You doing business as South Phoenix Dentist to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my insurer. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services whether or not paid by my insurance. I authorize the release of any information relating to this claim to obtain payment. I authorize the use of this signature on all insurance submissions.

Signature of Patient	Date

This authorization will be valid from this date and shall expire in one year.

Financial Policy

Thank you for choosing Dentistry For You doing business as South Phoenix Dentist to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and a government issued photo ID. If your insurance or any personal information changes during the time you are a patient, it is your responsibility to inform our office with any of these changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

- As a **courtesy**, we will gladly bill your insurance. If you are a member of an HMO/DMO plan then the co-payment is due at the time of service. While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and understand that this is a contract between your employer, your insurance company and yourself. Please be aware that some and perhaps all of the services rendered may be not covered by your individual plan and you are ultimately responsible for the payment on your account.

- We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. If no payment is received on your account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that **"This will be the final notice for payment"**. If the party fails to contact our office after receiving such notice, your account will be sent to a collection agency.

- We ask that you either pay your estimated patient portion of the bill at the time of service, or that a suitable written financial arrangement be reached at the time of service. We accept cash, all major credit cards, personal checks, financing from Care Credit and Simple Pay. For all checks returned due to **non-sufficient funds**, there will be a $35 fee added to your account.

- If an insurance company pays more than anticipated creating a credit balance on your account, we are happy to either refund the credit to you or leave the credit on your account to be applied to a future treatment.

- The original dental record, including but not limited to treatment notes, x-rays, and study models are the property of doing business as South Phoenix Dentist. These originals will not be released to you or other healthcare providers without written request. I understand that a $25 fee may be applied to my account for duplication of my dental records and x-rays.

Delinquent Accounts

On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding. In addition, a 35% collection fee based on the balance of your account will be added.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that you give us 24 hours' notice for cancellations; otherwise, we reserve the right to charge a minimum of $25 per hour of your scheduled appointment. This will be assessed to your account (I.E. 1hr or less appointment= $25 charge, 2hr appointment= $50, etc.). We will not offer appointments to patients who cancel or non-show to his/her scheduled appointment without having given us proper notice.

I confirm that I have read and understand this form or it was read to me and all of my questions have been answered to my satisfaction.

Patient Name Signature of Patient or Guardian Date