STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the State, Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records are always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

ACKNOWLEDGEMENT OF RECEIPTS OF

STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Diamond Smiles Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Diamond Smiles Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPPA rules.

Spouse only ……	_____YES _____ NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)……	_____YES _____ NO
Any Member of my extended family: (Parents, Grandchildren)……..	_____YES_____ NO
Other: ……	_____YES_____NO

_____

Printed name of patient (if 18 years or older) or responsible party

_____

Relationship to patient

_____

Signature of patient (if 18 years or older), or responsible party

_____

Responsible party contact information (phone or email)

_____

Date

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment? _____ YES _____ NO Date Statement Provided: _____

Reason for not obtaining patient signature:

____ Needed more time to review Statement of Privacy Practices
____ Wanted to consult another person before signing
____ Physically unable to sign
____ No reason offered
____ Other: _____

FINANCIAL POLICY

Welcome to Diamond Smiles Dentistry, where our team of dental professionals are committed to making your every visit relaxing and productive. Please sign this document to acknowledge your understanding of our Financial Policy.

DENTAL INSURANCE

You have a contract with your dental insurance company; we are not a party to that contract. While we do our best to obtain accurate information from your insurance company on your behalf, it is ultimately your responsibility to understand your policy and its limitations. Regardless of whether we are in network for your insurance, the final responsibility for all charges associated with your treatment lies with you – the patient.

ESTIMATES

We solicit an estimate from your dental insurance company, that you should consider a guideline until final insurance payment is received and your account has been reconciled. We make every effort to provide accurate estimates, but our office can make no guarantee that insurance payments will match our estimates.

CLAIMS

We promptly submit a claim to your insurance company after treatment. Any claim that is unpaid is billed directly to you.

PREDETERMINATIONS

At your request, we will gladly process your predetermination, but please be aware that predeterminations are not guarantees of payment.

PAYMENT IS DUE AT THE TIME OF SERVICE

You may have an out-of-pocket portion (coinsurance) which is determined by information and percentages provided by your insurance company. Your coinsurance portion will be presented in an estimate prior to scheduling your appointment. A deposit or prepayment is required to hold an appointment and is calculated based on the treatment scheduled, duration of appointment, time and day of the week.

APPOINTMENT CANCELLATIONS

We understand that sometimes you will need to reschedule your treatment. We respectfully request that you provide us with 48 hours advance notice. If your appointment is on a Saturday or Monday, we request 72 hours advance notice, as Saturday appointments are in very high demand. Without this notice, you will be charged $50.00 per half hour of missed appointment time.

SERVICE CHARGES

Accounts which are 60 days past due are assessed a monthly finance charge equivalent to an annual rate of 10.0%. Outstanding balances and applicable fees will be forwarded to third-party collections after 120 days of no response.

SERVICES NOT COVERED

You (or the party responsible for your account) agree to provide payment in full for procedures performed in this office, including any treatment not covered by your dental insurance.

WE ACCEPT CASH, TELECHECK, CARE CREDIT, MONEY ORDERS AND MOST MAJOR CREDIT CARDS

I have read, understand, and agree to this Financial Policy.

_____

Printed name of patient or responsible party

_____

Relationship to patient

_____

Signature of patient, parent or guardian

_____

Date