Notice of Privacy Practices & HIPAA Consent

Patient Privacy is important to our practice. We are required by law to maintain privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI.

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: ________________________________

Name: ________________________________ Relationship: ________________________________

____
Name of person signing (Please Print)

____ ____________________________
This HIPAA Consent/Sharing was signed by (Signature) *Today's Date*

____
Relationship to Patient (if other than patient)

Financial Consent & Office Guidelines

Dental Health Partners is committed to providing all patients with exceptional service and quality care. Please review our financial consent and office guidelines then sign/date below. Thank you.

Financial Obligation & Payment Guidelines

Please initial on the line next to the following consent after reading thoroughly:

_________***All patients***: I understand that any responsibility for payment of services provided in this office for me and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. Any quoted fees will be honored for a period of 6 months. I am aware that any balance carried past 90 days will be subject to a 5% rebilling fee at each statement period thereafter, as well as being sent to collections.

....

I choose the following method of payment for my dental care and the care of my dependents:

( )Patients with dental benefits: I authorize Dental Health Partners and their staff to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to them, and to handle any necessary claim appeal(s) on my behalf. **I understand that it is MY RESPONSIBILITY to know my specific plan/policy coverage.** I understand that if a pre-treatment estimate has been sent to my insurance company that this is not a guarantee of payment. I understand my dental benefits may cover more or less than is estimated, if any. Therefore, I understand after payment (if any) is received from my insurance I will be sent a statement with any remaining balance asking for payment in full.

OR

( ) Patients without dental benefits: I understand I am required to pay in full at the time services are rendered.

....

All balances must be paid in full within 90 days to avoid being sent to collections.

Payment Plan Options

Dental Health Partners accepts cash, checks, and all major credit cards as forms of payment.
Our payment plan option is offered through Care Credit. Care Credit offers deferred interest payment options along with extended payment plans. Log on to www.carecredit.com or call (800) 365-8295 for more information. Brochures are available upon request.
If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these guidelines. These guidelines will enable us to better serve the needs of all patients.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment, we require a minimum of a **24 hour notice**. You may leave a message at any time, within 48 hours, by calling (605) 996-1316. 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. We record all appointments, cancellation and no show appointments. We discourage repeat abuse of our scheduling guidelines which may result in dismissal from the practice.

I have read and understand the above guidelines.

____

Print Name of Patient or Guardian

____ ____________________

Signature of Patient or Guardian *Today's Date*