# OFFICE POLICIES FORM

**| DOB:**

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 212 Ohio St, Oshkosh, WI 54902, oshkosh, WI 54902:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient Signature

Date


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# FINANCIAL POLICY

## FINANCIAL POLICY

We are committed to providing you with the highest quality dental care. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any appointment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

## PLEASE NOTE:

All patients are responsible for full payment, or any co-payment estimate at time of service. **The parent or guardian accompanying a minor is responsible for their payment, unless previously agreed upon.**

We accept cash, check, Visa, MasterCard, Discover, or CareCredit.

## CANCELED AND MISSED APPOINTMENTS

Please help us service you better by keeping scheduled appointments. If you do need to reschedule, we require a 24-hour notice. Appointments not canceled with a 24-hour notice are subject to a $50 cancelation fee. Any missed appointments will automatically be charged a $50 fee.

## INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not

with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. We will, of course, do all we can to make sure your estimate is as accurate as possible.

While the filling of insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered. If payment is not received or your claim is denied, you will be responsible for paying the full amount. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately.

COLLECTION AGENCY PLACEMENT POLICY

You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for all collection agency fees up to 33% of the amount placed with the collection agency. In the event we seek legal action for collection on your account, you will also be responsible for all fees associated with court costs, garnishments, and/or attorney fees

In addition, all payments returned due to non-sufficient funds will be subject to an additional $35 fee.

I acknowledge that I have read this Financial Responsibility Form in its entirety, and that I understand and agree to the above terms and conditions.

_____ _____

Patient Signature Date


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