Acknowledgment of Privacy Practices & Office Policies

HIPAA Policy:

My signature confirms that I have been informed of my privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information will be used to:

- Provide and coordinate my treatment among A number of healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of the *Notice of Privacy Practices* and understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact his office at the address below to obtain a current Copy of the notice of privacy practices.

I understand I have the right to request restrictions as to how am I protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required to agree to the restrictions requested.

Financial Policy:

Payment is due at the time of service and as the patient you are responsible for all charges. However, if you are a patient with documentation of private insurance, as a courtesy we will bill your insurance provider for you at no charge. Please plan to pay your deductible and any applicable co-pay fees at the time of service.

Chair Reservation Policy:

As a small office, all missed appointments or late arrivals harm our ability to serve each of our patients effectively. All patients must call to cancel appointments 48 hours in advance, and without 48 hours notice will be charged a $50 fee for each occurance.

Returned Check Policy:

We gladly accept payment in the form of a personal payable, returned checks due to insufficient funds will be subject to a $50 fee payable by cashier's check, cash, or credit card.

I fully understand that I am responsible for all charges in the event of non-payment by my insurance company. I have read and understand the HIPAA, Financial, Chair Reservation & Returned Check Policies. I have received a copy of the Dental Material Fact Sheet. I give consent for the office of Richard J. Koeltl, D.D.S. to bill my insurance and receive payments directly from them. I agree to notify the office in the event of address, telephone number, employment or insurance coverage changes.

Patient Name ____ **Date** ____________________________

Patient/Responsible Party Signature _____________________ **Relationship to Patient** _______________