Smith and Bailey Dental Office Policies

Please read carefully, initial next to each item, and sign where requested.

___ As a courtesy to you, we will gladly file claims to your insurance company on your behalf. We will also provide an estimate of your out-of-pocket cost for a procedure, and we will collect that estimated amount at the time of service. But please understand that it is only an estimate; there are hundreds of different insurance plans and we cannot and do not know the details of every one.

___ Regardless of any estimate of insurance coverage we may give you, you are responsible for the total treatment fee. If your insurance pays less than we estimated, or does not pay at all, you will be billed for the balance.

___ If your insurance plan has not paid within 60 days, you will receive a bill for the balance. That bill should be paid within 30 days.

___ If your account becomes 120 days past due, it will be sent to collections. By signing below, you agree to be responsible for any and all collection fees and/or reasonable attorney fees.

___ We do our best to be respectful of your time when you are in our office. We strive to seat you at your specified appointment time, and to complete your treatment in a timely manner. We do not "double-book" in this office; when you make an appointment with us, we reserve a room and team member exclusively for you. For that reason, **we request at least 24 hours notice of any cancellation or change in appointment.**

___ If there is a habit of last-minute cancellations or no-shows, we reserve the right to apply a $25 broken appointment fee, and/or to require prepayment in full before any future appointments are scheduled.

___ We will contact you by phone, email and/or text message to confirm your appointments. PLEASE REPLY to our message(s) so we know you plan to be here. If you do not reply, we reserve the right to give your appointment time to someone else who needs it.

___ At Smith and Bailey Dental we are committed to offering the highest level of patient care. We encourage your feedback by responding to our review request which are hosted by Google and Facebook. Your review could be become public if you consent to such publication.

___ We discourage children and other family members from accompanying you to the treatment area. We want to be able to focus solely on you and unfortunately are not able to do so if others are in the room.

___ Please silence your cell phone when you enter the treatment area. We cannot give you the attention and care you deserve if you are talking/texting while in the dental chair.

***Please sign to indicate you have read and understood the above office policies.**

Patient Name (please print) _____

Signature of patient: _____ Date _____
(Or parent/guardian if patient is a minor)

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company, and as such, **I am accepting full financial responsibility for all charges for services or items provided to me or patient.** I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

This form will also give authorization for my doctor to release any dental or medical information necessary to process any insurance claims, for treatment and for general health care operations. This includes, allowing the release of information to any specialty care provider or entity that I am referred to.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature of patient,
parent or guardian

_____Date: _____ Relationship to Patient:_____
Signature of guarantor of payment/
responsible party

X-Ray and Records Release

I authorize x-rays and medical/dental records to be sent by unencrypted or unprotected email to other doctors, insurance companies or directly to myself when necessary. I am aware that I may be asked to fill out a post-appointment survey, and if I choose to do so, my comments and any information I provide may be viewable on third-party web sites on the internet.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the RELEASE.

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Authorization For release of Identifying Health Information

I authorize the professional office of my dentist named above to release health information identifying me
[including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. PLEASE TYPE THE NAME/NAMES OF WHOM YOUR INFORMATION MAY BE RELEASED TO/DISCUSSED (IF NONE, LEAVE BLANK):

3. The purpose(S) for the release (if the authorization is initiated by the individual, it is permissible to State ”at the request of the individual” as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you
if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization, If you want to revoke your authorization, Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, State or federal law changes this possibillity.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from
a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

If you are signing as a personal representative of the patient, describe your relationship to the patient and
the source of your authority to sign this form:

Relationship to Patient

Source of Authority

Signature_____

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Signature_____