Szmanda Dental Center - Office Policies

Thank you for choosing Szmanda Dental Center for your family's dental needs. We are committed to maintaining high standards of comprehensive dental care and believe financial considerations should not be an obstacle to obtaining care. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we provide multiple payment options, as listed below.

Responsible Party: _____

Family Members to be listed on this account**:**_____

_____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Primary Cell Phone: _____

Do you have dental insurance that we may submit on your behalf? Yes / No Please list below:

Primary Insurance Coverage carried by:	**Secondary Insurance Coverage carried by:**
Name: _____	Name: _____
DOB: _____	DOB: _____
Employer: _____	Employer: _____
Ins. Company: _____	Ins. Company: _____
Subscriber Number: _____	Subscriber Number: _____
Group Number: _____	Group Number: _____

INSURANCE BILLING POLICY: Please note that the above listed plan(s) constitute an agreement between you and your insurance company and we will do everything possible to help you receive the full benefits of your policy. Unfortunately, we are unable to make any guarantee of coverage or reimbursement and ask that all copays be paid at the time of service. Any outstanding insurance claim older than 60 days will become the patient's full responsibility.

PAYMENT POLICY: If you do not have insurance available to you, we extend a 5% administrative discount on all fees when paid at the time of service. On treatment plans over $500, we ask that you pay half on the first day of treatment and the balance upon completion. We accept cash, check, Mastercard, Visa, and Care Credit. Care Credit is a healthcare credit card designed to help you make convenient monthly payments with no prepayment penalty or application fee. Please see a Patient Care Coordinator if you'd like to learn more or visit their website at: **www.carecredit.com**.

CANCELLATION POLICY: We understand that unplanned circumstances arise and you may need to reschedule/cancel an appointment. If this occurs, we respectfully ask that you cancel at least 24 hours in advance. An appointment missed with no notice given will be documented as a "failed" appointment and a $50 administrative fee will be assessed. Three or more failed appointments may require that we dismiss you from our care. The goal of this policy is to make available as many unused appointments as possible to those patients seeking our care.

(TURN OVER)

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HIPAA POLICY: Our Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices provides information about how we may use or disclose your protected health information and we extend a copy to you today. The policy contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our policy before signing this consent. The terms of the notice may change, and if so, you will be notified at your next visit to update your consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA law allows for the use of the information to be shared for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information for these reasons. You have the right to revoke this consent by written notification. However, such a revocation will not be retroactive.

May we phone, email, or send a text to you to confirm appointments? YES NO (circle one)

May we leave a message on your answering machine at home or on your cell phone? YES NO (circle one)

May we discuss your medical condition with any member of your family? YES NO (circle one)
If YES, please name the members below:

_____

_____

By signing this form, I understand and agree that:

- My health information may be disclosed or used for treatment, payment, or healthcare operations.
- Szmanda Dental Center reserves the right to change the privacy policy as allowed by law.
- I have the right to restrict the use of my protected health information.
- I have the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may deem it necessary to alter receipt of treatment upon failed acceptance of this consent.
- I have been offered a copy of Szmanda Dental Center's Privacy Practices.
- I am the responsible party for this account and will comply with Szmanda Dental Center's policies.

Responsible Party: _____ Date: _____

Szmanda Dental Center Employee: _____ Date: _____