**OFFICE FINANCIAL POLICY**

At our dental office, our goal is to provide and maintain quality of care for you and your family. In order to ensure good flow of communication we want to let you know in advance of our office financial policy. Please read this carefully and if you have any questions, do not hesitate to ask a member of our staff. **Please initial each statement below.**

1. \_\_\_\_\_\_\_ On arrival, please check in at the front desk and let us know of any changes in insurance, address or phone number.
2. \_\_\_\_\_\_\_ Co-pays are due at time of visit. You are responsible for the balance on your account at this time as well.
3. \_\_\_\_\_\_\_ If you have no insurance, payment for the visit is to be paid at the front desk.
4. \_\_\_\_\_\_\_ The office of Christine M. Adams, DMD has the right to revise fees at any time, for any procedure which has not yet been started. During the course of my dental care, unexpected complications or new conditions may arise that may result in higher cost. If my treatment becomes too complex to manage, it may be necessary for me to be referred to a specialist to receive the care I need. Should this occur, I understand that I will be expected to pay the specialist for treatment.
5. \_\_\_\_\_\_\_ Patient balances are billed immediately on receipt of your insurance plan’s explanation of benefits. Your remittance is due within *thirty* business days of the receipt of your bill.
6. \_\_\_\_\_\_\_ Returned checks will incur a $35 fee plus any bank fees incurred.
7. \_\_\_\_\_\_\_ Balances over 180 days old will be forwarded to a collection agency.

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the above information and understand it fully. I will notify this office of any changes in my dental insurance or any other personal information that I have provided on the health history form. I certify that this information is true and correct.

I hereby authorize the dentist to furnish information to the insurance carrier concerning dental services rendered. I also authorize the insurance carrier to make payments directly to this office. I understand that I am responsible for any amount not covered by insurance. I agree to pay all balances in full within 30 days of receiving a statement unless arrangements have been made in advance. If you have any questions regarding the financial policy, please do not hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that a copy has been placed in your records.

**Patient Name Guarantor Signature Date**

**OFFICE POLICIES**

Thank you for choosing our office to provide dental care for you and your family. Please read our office policy information carefully. We are available to answer any questions you may have. PLEASE INITIAL EACH STATEMENT indicating your understanding and agreement of each policy.

1. \_\_\_\_\_\_ Please read and initial our financial policy which is included in the packet.
2. \_\_\_\_\_\_ We schedule visits by appointment only. Our office is open from 8am to 5pm Monday through Thursday. We will take calls for appointments starting at 8:30am. After hours, we are available on call for urgent dental emergencies.
3. \_\_\_\_\_\_ Missed appointments make it difficult to care for our patients. Please remember that there are other patients who would have like the time set aside for your visit. For scheduled appointments, please call 24 hours in advance if you need to cancel or reschedule your visit. **Failure to do so will incur a $40 fee.**
4. \_\_\_\_\_\_ Please allow 3-5 business days to process prescription refills. Refill requests will not be processed after hours or on weekends.
5. \_\_\_\_\_\_ ***Consent to treat:*** As a consenting adult, I agree to permit the staff at the office of Christine M. Adams, DMD to provide dental care to myself, my child or patient representative as applicable.
6. \_\_\_\_\_\_\_ ***Emergency care***: Emergency treatment for relief of severe discomfort is available, but during normal business hours only. After-hours emergency treatment is available on a limited, case-by-case basis, but is not guaranteed.
7. ***\_\_\_\_\_\_\_ Right to discontinue treatment:*** The office of Christine M. Adams, DMD has the right to discontinue treatment for any appropriate reason, such as, excessive cancellations or inappropriate conduct, and/or at the doctor’s discretion. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of Christine M. Adams, DMD. Records and x-rays will be duplicated upon written request with a reasonable charge to the patient.
8. ***\_\_\_\_\_\_\_ Risks of treatment:*** Dr. Christine Adams is available to answer any questions concerning the risks involved with specific procedures. All dental procedures have certain risks; including possible side effects from some medicines used in dentistry. These risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising from injections and/or sensitive teeth following dental procedures.
9. ***\_\_\_\_\_\_\_ Consent to treatment:*** By signing below, I am indicating that I have read and I understand the terms of the Consent and Agreement for Treatment. I am either the patient or have the authority to give consent for the patient. I give consent to Christine M. Adams, DMD to perform necessary or appropriate tasks for proper dental and physical examination, diagnosis, and treatment, including local anesthesia.

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

**Patient Name Signature (Relationship to patient if minor) Date**

**NO SHOW FEE POLICY**

Each time a patient misses an appointment without providing proper notice (24 hours prior to all appointments), another patient is prevented from receiving care. Therefore, Christine M. Adams, DMD reserves the right to charge a fee of $40.00 for all missed appointments (“no shows”). The “No Show” fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

For a “No Show” on a restorative visit with Dr. Adams, the fee will be billed to the patient and a deposit (will vary depending on treatment) will be required to re-appoint.

Thank you for understanding and cooperation as we strive to best serve our patients.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of Privacy Practices**

Our practice is dedicated to maintaining the privacy of health information that can be identified directly with you or your family. This is not meant to alarm you. We want you to know that we are taking the Federal Privacy Laws (HIPAA-Health Insurance Portability and Accountability Act) seriously. These laws were written to protect the confidentiality of your health information.

In conducting the business of our practice, we will create records regarding your treatment and the services we provide. We will maintain to the best of our ability the confidentiality of health information that specifically identifies with you or your family. We will also provide you with this notice of our legal duties required by law and the privacy practices that we maintain concerning your families’ Protected Health Information (PHI).

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal Law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our patient.

**How your Health Information may be used:**

**To Provide Treatment:** we will use your PHI to treat you, including but not limited to: obtaining lab tests or to write a prescription. Many of the people that work for our practice including dentists, hygienists, assistants or staff may use your PHI to inform others that may assist in the care of you such as: your spouse, children or other immediate family members. Finally, we may disclose your health information to other doctors or physicians that may need this information to properly care for you or your family members.

**To Obtain Payment:** We may include your health information on invoices to collect payment from third parties for the care you may receive from us. We may contact your insurer and provide details regarding your treatment to determine if treatment is covered by said insurer, or to obtain prior approval. We may use your PHI to bill you directly for services and items.

**To Conduct Healthcare Operations:** Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to evaluate the quality of care you received from us. We may disclose your PHI to other healthcare providers and entities in order to assist in their healthcare operations. We may use your PHI for review, auditing, compliance, medical/dental review, legal services, and administrative uses.

**Appointment Reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.

**Treatment Options**: Our practice may use and disclose your PHI to inform you of potential treatment options and alternatives.

**When Legally Required:** We will disclose your health information when it is required to do so by any Federal, State, or local law including, but not limited to, public health, national security as well as when we are legally required to release information to a law enforcement official including under certain limited circumstances if you or your family member is a victim of a crime, or in order to report a crime.

**When there are Risks to Public Health:** We may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of (1) maintaining vital records, (2) preventing or controlling disease, injury or disability, (3) notification of certain communicable disease, (4) notifying a person regarding potential exposure to communicable disease, (5) reporting reactions to drugs or problems with products or devices, (6) recalls of products or devices, (7) to conduct health oversight activities, (8) in connection with judicial and administrative proceedings as required by law i.e. in response to a court order or if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request or subpoena.

**For Law Enforcement Purposes:** As permitted or required by state law we may disclose you or your family member’s PHI to a law enforcement official, including, under certain circumstances, if you or your family member is the victim of a crime or in order to report a crime.

**Serious Threats to Health or Safety:** We may, consistent with applicable law and ethical standards of conduct, disclose you or your family member’s PHI if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to you or your family member’s health or safety or to the health and safety of the public.

**Patient Rights**

You have the following rights regarding health information that we maintain about you or family members:

**Confidential Communications:** You have the right to request that we communicate with you in a certain way. For example, you have the right to request that we only contact you at home, rather than work or privately without any other family member present. If you wish to receive confidential communications you must make a written request detailing your wishes. You do not have to provide a reason for request and every effort will be made to honor it.

**Requesting Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. For example, you may restrict our disclosure to only certain individuals involved in your requests. You must make your requests in writing to our office.

**Inspection and Copies of Health Information:** You have the right to inspect, read, review and copy the PHI including billing records. We request that you submit this information in writing in accordance with our office policies, including charging a reasonable fee for copying and assembling costs associated with your request in accordance with Florida Law.

**Right to Amend Health Information:** You have the right to amend you records if you believe the health information records are incorrect or incomplete. The request may be made as long as the information is maintained by us. A request for an amendment of records must be made in writing. You are required to provide us with a reason that supports you request for amendment. The request may be denied if you fail to submit your request in writing, if the record in question was not created by our office, is not part of our records or if the records in question are determined by us to be accurate and complete.

**Accounting disclosures:** You have the right to request an accounting of disclosures of your health information. In order to obtain, you must submit your request in writing. All requests must state a time period, which may not be longer than six years from date of disclosure. The first accounting you request during any 12-month period is free of charge, but subsequent requests may be subject to a reasonable cost-based fee.

**Right to file a complaint:**  You have the right to express complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

**We are required by law to maintain the privacy of your health information and to provide you with this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice; we do reserve the right to change the terms of our Notice. If we change our Privacy Notice, we will provide a copy of the revised Notice to you or your appointed representative. By signing below, I acknowledge receipt and accept the aforementioned Privacy Practices.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**