

HIPAA PRIVACY RULES

Patient Authorization Agreement **Authorization for the Disclosure of Protected Health Information** **for Treatment, Payment, or Healthcare Operations (§164.508(a))**

I understand that as part of my health care, Broadway Dental originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and treatment information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a copy (on the website, or on paper) of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have the right to review the notice prior to providing my authorization.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I authorize the disclosure of my Protected Health Information as specified below for these purposes and to the parties designated by me.

Patient Consent Agreement **Consent to the Use and Disclosure of Protected Health Information for Treatment,** **Payment, or Healthcare Operations (§164.506(a))**

I understand that:

- I have the right to review Broadway Dental's Notice of Privacy Practices prior to providing my consent;
- Broadway Dental reserves the right to change the notice and practices and, prior to implementation, will post or mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations, but that Broadway Dental is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that Broadway Dental has already taken action in reliance thereon;
- It is Broadway Dental's procedure to share Protected Health Information with labs, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange the minimum necessary Protected Health Information for each transaction.

Acknowledgment of Receipt of Dental Materials Fact Sheet

I have been offered and/or received a copy of the Dental Materials Fact Sheet as required by law.

Signature (*Guardian's signature if patient is under the age of 18.*)

Date

OFFICE POLICIES

Welcome to our office! Choosing our office for your dental care was your first step toward excellent dental health. We make an honest effort to provide you the best dental services possible, with the utmost attention given to COMPLETE STERILIZATION of instruments.

- ▶ We will give you explanations before you ask, but you have the right and obligation to question anything and everything that is not clear to you. We enjoy questions, so please ask.
- ▶ If you have been waiting in the waiting room for more than 15 minutes, please notify the receptionist. We'll do our best to seat you right away.
- ▶ To keep your waiting to a minimum, we encourage morning appointments. Make only those appointments you can keep. Cancellations or missed appointments without at least a 24-hour notice are charged appropriately — no exceptions.
- ▶ We share your concern about your children and loved ones. Be assured that we will treat them with all the care you expect. However, parents, relatives, and friends **MUST** wait in the waiting room at all times.
- ▶ For your convenience, cash, checks, and major credit cards (with driver's license) are accepted.
- ▶ All copayments for services must be paid on the day of your appointment before you are taken in.
- ▶ Checks not honored by your bank ("bounced") will result in a minimum \$50 service charge to your account. We also reserve the right to charge the maximum amount allowed by law.
- ▶ We will estimate what your benefits are, but it is **ONLY** an estimate. What your insurance does not cover or pay for, you are responsible for. Any balance on your account is fully your responsibility. For example, if your insurance company provides us with your coverage eligibility dates but later, at the time of billing, claims you were not eligible due to policy termination, employment changes, cancellation, or any other reason including error, even if you were not aware of the change or error, **YOU** are responsible for all charges. Know that your insurance coverage is **YOUR** responsibility, regardless of what information, accurate or not, was provided to us by your insurance company.
- ▶ For x-ray or record duplication for any purpose, there is a \$30.00 service fee for each service. Any original documents, x-rays, or models taken in this office are the property of Broadway Dental Group.
- ▶ Delinquent accounts are charged a 5% late fee per month (minimum \$25.00 per month). Extended delinquencies beyond 90 days will affect your credit rating and result in legal action.
- ▶ In case of default in payment of any sums of money for services rendered, patient (legal responsible party) hereby agrees to pay a reasonable attorney fee, late fees, and all court costs incurred by the holder in such action. Said party hereby waives, to the fullest extent permitted by law, diligence, demand, protest, notice of protest, and the benefit of any statute of limitation.

Patient's Signature (*Guardian's signature if patient is under the age of 18.*)

Date