HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand that by signing this consent, I authorize Snowy River Dental to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we will help you maximize your allowable benefits.

<u>Please (√) the option(s) most convenient for you to settle your account:</u>

□ Cash/Check/Debit □ Visa □ Mastercard □ Am Express □ Discover
□ Care Credit(*please see receptionist for application form*)

Due to the constantly changing insurance contracts, benefits, and deductibles we are only able to **ESTIMATE** your insurance coverage. As a courtesy to you, we will file your insurance claim at no additional charge. All out of pocket portions, including deductibles, are due in FULL at time of service.
In consideration of treatment by the doctor, I, undersigned, jointly and severally, understand and agree:

- To be responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize. I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to the doctor.
- To pay interest at the rate of 18% on all monthly balances over 60 days from the original due date unless prior payment arrangements have been made.
- Will be responsible if account goes to collections for all court costs and attorney fees.

_______________________________________ _______________________________
Signature Date

*If signing on behalf of someone, explain your relationship to the patient: ________________________________
*If you would like a copy of our HIPAA policy please ask the receptionist.

<u>OFFICE USE ONLY</u>
Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.
Describe reason of refusal: ____

_______________________________________ _______________________________
Office Personnel Signature Office Personnel Name

_______________________________________ _______________________________
Office Personnel Title Date