Priscilla Cury Rosa DDS A Dental Corp.
2835 W Lincoln Ave, Anaheim, CA 92801
Phone: (714)886-2297

HIPPA NOTICE AND OFFICE POLICIES

HIPPA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's HIPPA Notice of privacy practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise this rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

CANCELATION AND BROKEN APPOINTMENT POLICY

When you make an appointment, we reserve the time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We respectfully ask that you give us a minimum of 48 hours' notice. **We reserve the right to charge for any appointment (s) broken without a 24 hours' notice. The charge will be $50.**

Signature: _____ Date: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

The charge for checks returned form the bank is subject to a **$35** service fee. Since your insurance company only pays for the services and the reading of the X-rays, a **$30 fee will be charged for copies of X-Rays requested by patients**. Accounts delinquent more than 60 days will be send to our collection agency. We welcome you to your office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

Private Patients

Patients without insurance coverage are required to pay on the day services are rendered, unless specific arrangements are made in advanced. We accept cash, Visa, MasterCard, American Express and Discover, or Debit/ATM cards. We also accept financing through Care Credit.

Insurance Patients

For those patients covered by insurance, we may accept assignments of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% for the cost of your treatment. In this day and age many cover 50% or less on many services, and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your **ESTIMATED co-payment** on the day services are rendered. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they will tell us what they will cover on the treatment plan. If we do accept assign of benefits from the insurance company, if the insurance company hasn't paid after 45 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing and agreeing to financial responsibility.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and /or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents. Also, 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.

Thank you for reading and understanding our financial policy. If you have any questions or concerns, please feel free to ask them at any time. We wish to be of assistance in any way we can.

Sincerely, Blue Horizon Dental

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

_____ **Date**: _____

Signature of responsible party

_____

Please print your name