

Agreement

Initial_____

I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or unless Dr. Nekia Staley-Neither, doing business as, Special Care Dentistry, has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information (PHI) to carry out payment activities in connection with any and all claims.

Assignment of Benefits

Initial_____

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to:

Special Care Dentistry
6117 Marlboro Pike
District Heights, MD 20747

Privacy Notice

Initial_____

Dr. Nekia Staley-Neither, doing business as, Special Care Dentistry, keeps a record of the dental care services that are provided to you. Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed and how you can access that information. We will not disclose your record to others (except in the circumstances described in our Notice of Privacy Practices) unless you direct us to do so, unless the law authorizes us to do so, or unless circumstances compel us to do so. You may ask to see a copy of your record or get more information about it by contacting:

Special Care Dentistry
6117 Marlboro Pike
District Heights, MD 20747

If you find information in your record to be incorrect, you may ask that the record be corrected by writing to the above address.

By my initialing above, I acknowledge that I have read, been given the opportunity to read, and/or have been provided a copy Special Care Dentistry's Notice of Privacy Practices.

Financial Policy

Initial_____

We cooperate fully with our patients who are covered by insurance plans. We expect insured patients to read their policies carefully. It is very important that you are familiar with its benefits and limitations. We will accept assignment of benefits provided the necessary documentation has been provided. We do require that you pay your deductible and/or estimated co-pay at the time of service. If your insurance company has not paid your account in full within 45 days of treatment or denies your claim for ANY reason, you are responsible for the total balance.

All estimates given for proposed treatment are not a guarantee of benefits. The office does not allow the insurance company to dictate recommended treatment. All prosthetic services must be paid in full on or before completion. We reserve the right to charge any account balance due over 30 days a 1.5% monthly finance charge or a \$5.00 repeat billing charge, whichever is greater. You are responsible for any and all collection cost and/or fees associated with collecting the balance of your account. We consider the parent or guardian who brings the child to our office for treatment the responsible party for payment of the child's account. If someone else is legally responsible for the child's account, it remains the responsibility of the parent or guardian bringing the child in for treatment to seek reimbursement for payment made to our office. We will be happy to assist you by providing you with a copy of the charges and payments made at each visit. The office reserves the right to charge \$50.00 **PER HALF HOUR** of a broken appointment. To avoid a charge, 48 hours notice must be given. A \$50.00 fee will be added to your account for any checks returned to us by the bank. An \$25.00 fee will be assessed for the duplication of records/x-rays.

Notice of Privacy Practices

Initial _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment Means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personnel friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____