MODERN SMILES

COSMETIC DENTISTRY

10545 Victory Blvd
North Hollywood CA 91606

(818) 763-9353
www.modernsmiles.com

HIPAA INFORMATION and CONSENT FORM

The Health Insurance Portability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected health information (PHI). Their restrictions do not include normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically included the sharing of information with other health care providers, laboratories, health insurance payers as it is necessary and appropriate for your care. Patient files may be stored in open racks and will not contain any coding which identifies a patient's condition of information with is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examinations room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents of information.

2. It is the policy of this office to remind patients of their appointments. We may do this be telephone, email, U.S. mail, or by any means convenient for the practice and/or requested by you. We may send you other communication informing you of changes to office policy and new technology that you might find valuable of informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the performance of their duties.

5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager of the doctor.

6. Your confidential information will not be used for the purpose of marketing of advertising of product, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to the request.

I, _____ Date_____

do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information for and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to your first appointment.

All patients must complete our "Patient Information Form" before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE:
For non-insurance patients, full payment is due at the time of service. We accept cash, checks, and Visa/MasterCard/American Express and Discover. We do offer an easy payment plan through Care Credit upon credit approval.

ADULT PATIENTS:
Adult patients are responsible for payment at the time of service.

MINOR PATIENTS:
The adult accompanying a minor and the parents (or guardian) is responsible for payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved Visa/MasterCard/American Express/Discover, cash or check.

INSURANCE:
If you have insurance, all estimated co-payments are due at the time of service. As a courtesy to our patients, we will call your insurance before any major treatment is performed and get your estimated co-payment amount.

Although we do verify your insurance over the phone, please understand that this is just an estimate. Your insurance decides to cover procedures at their discretion once they review the claim form. They may pay slightly more than our estimate or they may pay slightly less. Once your insurance pays, if there is a balance left over, the Patient/Parent/Guardian is responsible for that balance.

We encourage all of our patients to touch base with their insurance before any treatment and educate themselves on their insurance.

MISSED APPOINTMENTS:
x_____ **Appointments must be cancelled with at least 48hrs business day notice.** If less then 48hrs business day notice, our policy is to charge a minimum of **$75.00**. This fee will increase if the missed appointment is a lengthy appointment. We do understand that emergencies come up in life. But please help us serve our patients better by honoring this missed appointment policy.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

X_____ _____
Signature-Patient or Responsible Party Date