Dear Patient:

As a health care provider, our office is subject to State and Federal laws regarding the confidentiality of your health information. In keeping with these laws, we want you to understand our procedures and your rights as our valuable patient. We are taking the new Federal ***HIPAA - Health Insurance Portability and Accountability Act*** laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay your treatment because you are afraid your health information might be unnecessarily made available to others outside of our office.

We will use and communicate your health information ***only*** for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

Yes, it creates more paperwork, but when you complete and sign these forms, we become partners in protecting the privacy of your health information. ***If you have any questions, one of our team members will be happy to assist you.***

HECK FAMILY DENTISTRY
BRIAN W. HECK D.D.S., P.A.
CLAY A. BESHORE D.D.S., P.A.
NOTICE OF PRIVACY PRACTICES

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, if necessary.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read the "Notice of Privacy Practices" carefully and completely before signing this Consent. ***Please note: You may refuse to sign this consent. However, we cannot communicate with your insurance company without consent from you. You will then be required to file all insurance claims directly with your insurance company and pay fees in full at each visit.***

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and to review the Notice of Privacy Practices. ***I understand that, by signing this form, I am giving my consent to you for use and disclosure of my protected health information to carry out treatment, payment activities and health care operations for myself (and applicable members of my family under the age of 18), when necessary. I have been given the opportunity to keep a copy of the "Notice of Privacy Practices" for my records if I desire.***

Names of all patients in family (under the age of 18):	1.	2.
	3.	4.

Signature: X_____ **Date:** X_____
Patient (if child, parent/legal guardian)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

? Individual refused to sign ? Communications barriers prohibited obtaining the acknowledgement
? An emergency situation prevented us from obtaining acknowledgement
? Other (Please Specify): _____

Financial Agreement

Dental Service

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle and efficient manner. Since our practice is also a business with obligations that must be met, we ask that **all patients pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made.** We accept cash, checks, or credit cards- an outside financial institution which offers NO INTEREST rates to finance your treatment if needed.

Claim Submissions

We are happy to file your insurance claim as a courtesy but keep in mind your dental policy is a contract between you, your employer and your insurance company. **You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.**

Co-payments

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very *close estimate* of your next visit's total bill. With a proper diagnosis and a timely treatment plan, most *estimates* we provide are accurate. **Because we cannot guarantee your exact insurance coverage, or perfectly predict all treatment outcomes; there may be a balance (or credit balance) remaining after insurance payment is received.**

Financial Agreement & Authorization for Treatment

I understand that any insurance estimate given to me by Heck Family Dentistry is not a guarantee of actual insurance payment and that I am ultimately responsible for all charges incurred for services performed on myself or my dependents, and agree to pay costs of collection including but not limited to court costs and reasonable attorney fees.

Please sign below stating that you understand and accept our payment policy.

_____ _____

Patient or Parental Guardian Signature Date

Cancellation & "No Show" Policy

The following are our policies regarding cancellations and "No Shows". We take this subject seriously as it can make the difference between whether you succeed in your treatment or not.

We require a **2 business day (our published days of operation) notice** in the event of a cancellation. The first time we do not get a 2 business day notice is a "grace miss" because we understand that sometimes things come up and there is absolutely nothing you can do about it. After that there is a per hour fee that coordinates with the length of your appointment if cancelled within 2 business days or for "no shows". First miss is $30, second miss is $40, then it's $60 (and stays at $60) per hour cancelled off our schedule.

When a patient does not show for an appointment, three people are affected: the patient because they do not receive the treatment as prescribed; the dentist or hygienist who now has a space in their schedule since the time was reserved for that patient; and another patient who could have been scheduled for treatment if there had been adequate notice.

Please sign below stating that you understand and accept our Cancellation and "No Show" policy.

_____ _____

Patient or Parental Guardian Signature Date