DiBartola Dental RPLLC

PATIENT 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 you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our 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 users and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent in not affected.

Patient Signature_____ Date_____

Informed Consent-Photographs

I understand that photographs, x-rays, models and other records may be taken during the course of my examination, treatment and follow-up care.

I give my permission for such items to be used for purposes of research, education, or publication in professional journals.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my dependents or me during the period of such dental care to third party payers and or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependants.

Patient Signature_____ Date_____

OFFICE FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Most times a deductible and co-payment is involved that must be paid by you. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time. We must emphasize that as dental care providers our relationship is with you, not your insurance company. Your Co-pay will be calculated by the financial coordinator and must be paid (4) days prior to treatment.

UNPAID BALANCES

For your convenience, we offer the following methods of payment. Your insurance may not cover all procedures performed or there may be a deductible that needs to be met. For your convenience we accept cash, personal checks, Care Credit, Visa, Master Card, Discover, American Express and Lending Club.

Return checks are subject to a bank fee. Any balances that insurance has not paid will be invoiced no more than two times. If your balance is not paid with in the two billing cycles your account will be sent a national collection agency. In an effort to defray the costs of collection proceedings, all accounts sent to collections would have a 25% charge added to the balance based on the unpaid invoice.

We do reserve time for your appointment and would appreciate at least 24 hours notice if you are unable to keep your appointment. If you do not cancel and do not keep your appointment, there will be a charge to cover the expense of reserving that time for you. This charge must be paid before we can schedule another appointment for you. Please feel free at any time to discuss any of the above information with our office coordinator. I have read all the above information and agree to the terms set forth.

Patient Signature_____ Date_____