OFFICE GUIDELINES

In order for us to provide high quality dental care in a relaxed environment we follow these guidelines. If you have any questions please do not hesitate to ask. We are happy to answer any questions you may have. ☺

HIPAA

In general, the HIPAA privacy rule gives individuals the right to request the restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as, sending correspondence to the individual office instead of the individual's home. The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

By signing this form, I give my Dentist permission to use and disclose any PHI necessary to carry out treatment, payment, and healthcare operations, this includes but is not limited to notes, X-rays, and photographs. This also indicates that I am aware of the offices "notice of privacy practices" posted in the waiting room.

Print Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date**: _____

I hereby voluntarily request and consent to the performance of treatment, medication, and/or therapy that may be indicated in connection with (Name of Patient - Printed) _____ and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. This consent shall remain in effect until revoked by patient or guardian.

SCHEDULING

Dr. Gritsiv and staff pride themselves on treating patients in a timely manner. To be able to accomplish this we ask that you respect our time as well and give us at least 24 hours notice if you are unable to be present for your scheduled appointment. We manage our schedules so that we can provide individualized attention to each patient. This means that your appointment time is reserved exclusively for you. Any change in this appointment affects the time that we are able to spend with you as well as the other patients treated that day. Should the need arise to cancel or reschedule your reserved time, a 24 hour advance notice is required. A 48 hour advance notice is required for reservations of 2 hours or longer so that we may give that time to another patient. We will make every effort to try to confirm your appointment. Insufficient notices to cancel or reschedule may result in additional charges. In consideration of other patients, your appointment will not be extended if you arrive late. Delayed arrival may result in the need to reschedule your appointment.

INSURANCE

If you have a dental benefit plan we will make every effort to help you maximize your benefits. We will be happy to assist you by submitting claim forms to your insurance company. However, please understand that we deal with many different insurance plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the unique requirements of each and every plan. Your plan may have limitations on the number of visits, x-rays, and procedures considered for payment. If you have any questions about whether a procedure will be considered for payment, please contact your insurance carrier before beginning the procedure. Any outstanding balance not paid by the insurance is the patient's responsibility. Of course, we always pride ourselves in providing proper care in the most cost effective manner.

For written pre-estimates, there is a $10 fee, which is taken-off when that treatment is completed. However, we find pre-authorizations to be so inaccurate, and time wasting, that we strongly discourage them.

PAYMENT

We are committed to the success of your treatment and we charge what is usual for our area. Payment is expected at the time of service unless other arrangements have been made in advance. We accept cash, check, credit cards, and Care Credit. If you are interested in financing treatment please ask our front office staff for details prior to receiving treatment. In order to keep our fees reasonable, we do not extend patient accounts beyond 60 days. If your insurance does not pay within 60 days from the balance will become your responsibility to pay or transfer to our financing company. A monthly interest rate of 1.5% will apply on all balances not paid within 90 days from the date services were provided. In the rare event that it is necessary to turn your account over to our collections agency, you will be responsible for additional collections fees.

I have read and understand the Office & Financial Guidelines above. All questions have been answered to my satisfaction. I understand that payment for Dental Services provided in this office for my dependents & myself is my responsibility, due and payable at the time services are rendered unless other arrangements have been made in advance. I will accept responsibility for all charges not paid by my insurance within 60 days from the Date of Service. A photocopy of this is to be considered as valid as the original.

SIGNATURE: _____ **DATE**: _____