Notice of HIPAA Privacy Practice

The Perfect Smile is required to maintain the privacy of your health and dental information and to provide you with a notice of legal duties and privacy practices. The Center will not use or disclose your protected dental information except as described in this notice. Protected Health Information is information about you which was created or received by The Perfect Smile and that relates to your past, present or future dental condition, or the provision of or payments for your health care which could be used to identify you. All uses and disclosures of protected dental information will follow HIPAA standards or policies

Examples of Disclosures for Treatment

Treatment: The Perfect Smile will use your dental information in the provision and coordination of your dental care. We may disclose all or any portion of your protected health information to your attending healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient.

Treatment Alternatives: The Perfect Smile may use and disclose your protected dental information to tell about or recommend possible treatment options or alternatives that may be if interest to you.

Billing and Payment: The Perfect Smile may release protected health information about you for the purpose of determining coverage, billing, claims management and reimbursement. The information maybe release to an insurance company , third party payer or other entity (or their authorized representative) involved in the payment of your bill and may include copies or excerpts of private records (i.e. radiographs) which are necessary for payment of your account.

HIPAA-Authorization to Release Protected Dental Information

I hereby authorize the release of any medical and private/protected dental information necessary to my treatment and process claims, and request payment from my insurance carrier

Patient Signature: ________________________________ Date: _____________________________

Assignment of Benefits, Facility Fees and Acknowledgement of Financial Responsibility

I hereby authorize my insurance company to pay by check made payable and mailed directly to The Perfect Smile.

For the dental benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, The Perfect Smile will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment.

Furthermore, I hereby acknowledge that any payment sent directly to me by my insurance company for dental services rendered by The Perfect Smile is for reimbursement of The Perfect Smile for provision of dental services. I hereby agree that such payment will be endorsed by me and/or the insurance and/or the responsible party if patient is a minor, and sent to The Perfect Smile immediately and directly.

All uses and disclosures of protected dental information will follow HIPAA standards and policies

The Perfect Smile Billing Policy:

Co-payments, co-insurance and deductibles for ambulatory services are due at the time of service. For patients with commercial insurance payment is due at the time of service.

Insurance Waiver of Liability Statement:

I have been notified that my insurer may deny payment for the service identified above. If the insurer denies payment, I agree to be personally and fully responsible for payment.

Patient Signature: ____ Date: ___________________________