

### Shuayb Dental Financial Policy

Thank you for choosing Shuayb Dental as your dental care provider. We are committed to quality patient care. The following is a statement of our financial policy, which we want you to fully understand prior to treatment.

Please understand that payment of your bill is considered part of your treatment plan. If you are unable to pay in full today, please inform the front desk personnel so that we may discuss the financing options available to you. Upon credit approval, you may be eligible for an available payment plan. **PAYMENT IS DUE AT THE TIME OF SERVICE.** We accept cash, checks, and most major credit cards. **THERE WILL BE A FEE FOR ANY RETURNED CHECKS.**

#### Regarding Insurance:

We may accept assignment of insurance benefits on your first visit to Shuayb Dental. This means that your insurance company will pay us instead of you. **HOWEVER, YOUR INSURANCE COMPANY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, WE HAVE NO CONTROL OVER THEIR DECISIONS AND THE AMOUNT THEY DECIDE TO PAY.**

Before filing a claim on your behalf, we will attempt to verify your coverage and calculate your deductible and co-payments as accurately as possible. **REMEMBER CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

You should be aware that your insurance company will not guarantee payment over the telephone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY DECIDES TO PAY, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once payment is received on your claim, we will send you a bill for any balance remaining on your account.

**IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE 24 HOURS NOTICE, FAILURE TO CALL AND CANCEL AN APPOINTMENT WILL RESULT IN A \$40.00 BROKEN APPOINTMENT FEE. IF YOU HAVE 3 MISSED APPOINTMENTS THIS WILL RESULT IN A PERMANENT DISMISSAL FROM THIS OFFICE. PLEASE NOTE THAT ESTIMATES ARE VALID FOR ONLY 30 DAYS AND IT'S THE PATIENTS RESPONSIBILITY TO RETAIN THEIR TREATMENT PLANS.**

I have read and understand the above Financial Policy. By signing below I acknowledge responsibility and agree to the terms as written above.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/ (or parent if a minor) signature: \_\_\_\_\_

### Shuayb Dental HIPPA Consent Form

**Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to these office personnel. 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, (Patient Name) \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and you're Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your practice to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also give my consent to Shuayb Dental to release my information to my spouse. If I choose against this, I will advise the front office staff.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent signature if patient is a minor \_\_\_\_\_

## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

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### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our private practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about your privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### Uses and Disclosures of Health Information

We use and disclose your health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communication without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.