OFFICE POLICY

PATIENT PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care options.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. Richard J. Staller, P.A. d/b/a Advanced Dentistry South Florida operates a wholly owned subsidiary Advanced Dentistry South Florida Specialists, LLC. If you receive treatment by Advanced Dentistry South Florida Specialists, LLC those records will be maintained by Richard J. Staller, P.A. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We support your full access to your personal dental records. Once a written records request is received, your personal dental records will be released within 14 (fourteen) business days. Fees may be incurred to copy these records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for in full at the time services are performed unless other arrangements are made. Deductibles and co-payments are due at the time of treatment.

We are pleased to be a provider for many insurance carriers and will work with dental insurance companies to maximize your benefits and directly bill them for reimbursement for your treatment. I authorize my insurance company to directly pay my dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize my dental office to release all necessary information to secure the payment of benefits. In the event your insurance company sends you a check as payment for the services provided here, by signing this form you have expressly agreed to irrevocably assign such payment(s) to Richard J. Staller, DDS PA and you further agree to immediately forward any payment(s) to Richard J. Staller DDS PA. Failure to forward a check that is intended to pay for services provided to you constitutes theft of assigned funds and is punishable by law.

I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered. If the insurance company does not pay your balance within 30 days, we will ask that you contact the carrier to help speed things up.

A fee of $100 is charged for patients who miss or cancel more than two times in one calendar year without twenty-four hour notice during business hours. Additional fees may apply for "after hour" appointments. (See section noted After Hour Appointments). A fee of $25 will be charged for returned checks. Balances older than 90 days may be subject to additional collection fees and interest charges.

Payment options include: cash, check, Visa, MasterCard, Discover, and American Express in addition to financing options if qualified.

PATIENT CARE

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We believe that an informed patient ends up as a happy patient. Many of the procedures in dentistry are complex and take multiple appointments, some of which may be lengthy in time. Also, due to the laboratory procedures involved, there may be weeks in between visits when no treatment is rendered. It is our goal to satisfy both the cosmetic and functional needs for our patients. While we will always do our best to please our patients, no one is as good as nature.

When fabricating dentures it should be remembered that each set is different due to the ever changing bone level and soft tissue of each patient. A wax try in (trial denture) will be made and the patient will be able to evaluate and make changes at this stage if necessary. Once accepted and completed, no changes can be made in the final denture without the patient incurring an additional fee. Also, after a period of time, it will become necessary to reline dentures to accommodate their fit.

While crown and bridge porcelain restorations most resemble natural teeth, there still may be some compromises in their fabrication. Also, during the lifetime of any restoration it may be necessary to repair or modify this restoration due to breakage or normal wear.

The utilization of gold collars or gold biting surfaces, the number of missing teeth, periodontal treatment, the incorporation of implants, and other factors may lead to compromises in case design. Therefore, ideal esthetics and function may be altered in an attempt to save a patient's teeth. Also, when removing existing crown and bridge, a treatment plan may be subject to change as it is not always possible to determine the health of a tooth under an existing crown. The utilization of a build-up material may be necessary to reconstruct a tooth during a crown appointment to gain more strength.

It should be noted that case success is dependent on many things, some of which include, patient health, patient resistance, home care and keeping up with maintenance visits. A designed hygiene recall program including examination and films must be followed and maintained. It is the responsibility of the patient if dental health is to be insured. The practice of dentistry is not an exact science and no guarantee can be made especially when dealing with healing and the other factors previously mentioned. When utilizing implants, case success is always dependent on the implant success.

It should be stated that during treatment or in the future, it may be necessary to refer a patient to other dental specialists such as an endodontist, periodontist, or oral surgeon. This additional cost is not included in our restorative fee.

AFTER HOUR APPOINTMENTS

There may be times when the office opens to accommodate patients before or after regular hours or during closed days (ie: weekends or holidays). During these times it is very important that those scheduled appointments are kept. A fee of **$100** is charged for patients who miss or cancel these appointments without twenty-four business hour notice.

EASY PAY

What is Easy Pay? Occasionally you will have obligations unbeknownst to us that have been set forth by your insurance company, leaving a balance on your account. We will always let you know if we feel a service may not be covered, however, ultimately the insurance contract is between you, your employer and your insurance company.

If we receive notice that there is a balance on your account due to insurance payment and/or missed appointments, your payment will be processed with the Easy Pay Service and you will be notified that your payment has been processed. If you request, we will also email or mail you a copy of your payment receipt.

Please complete the form below to authorize future payment of any balance on your account. Your billing information will be kept confidential and be guarded by the same patient privacy policy as all other patient information.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE OFFICE POLICIES SHOWN ABOVE.

_____ _____

NAME OF PATIENT TODAY'S DATE

_____

NAME OF GUARDIAN/RESPONSIBLE PARTY IF DIFFERENT

_____

SIGNATURE OF GUARDIAN/RESPONSIBLE PARTY

HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**: I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. **Effective Period**: This authorization for release of information covers the period of healthcare from:
   a. ☐ _____ to _____
   OR
   b. ☐ all past, present, and future periods.

3. **Extent of Authorization**:
   a. ☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   OR
   b. ☐ I authorize the release of my complete health record with the exception of the following information:
      ☐ Mental Health Records
      ☐ Communicable Diseases (including HIV and AIDS)
      ☐ Alcohol/Drug Abuse Treatment
      ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, as any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____ _____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date