ACKNOWLEDGEMENT OF RECEIPT OF *Notice of Privacy Practices*

HIPAA- HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA CONSENT FORM FOR YOUR CHILD

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my minor child's protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly. (Example - orthodontists or oral surgeons).
- Obtain payment from your insurance company.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Remind you of upcoming appointments, treatment options, or alternatives.

I have been given by Compassionate Dentistry/ Matthew Paper, DDS a copy of ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my minor child's health information to review prior to signing this consent.
I understand that this office has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this office at any time to obtain a current copy.

Matthew Paper, DDS
3900 Ten Oaks Road, Suite 5
Mail box 249
Glenelg, Maryland 21737
410-531-6600

Child's Name_____ Date of Birth____/____/_____

Signature of Parent/Guardian_____ Date____/____/_____

Printed name of Parent/Guardian_____

Authorization to Release Information

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding my minor child.
Example (Grandparent, Step-parent, Adult sibling, Aunt/Uncle)

Print Name_____ Relationship_____

Print Name_____ Relationship_____

Print Name_____ Relationship_____

Parent/Guardian signature_____ Date_____/____/_____

Updated Financial Policy

Thank you for entrusting your dental care to us. We appreciate the opportunity to serve you and are committed to your oral health and well being. We have found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask any questions you may have.

To All Patients:

In order to keep our fees reasonable and reduce billing costs,
please read and understand our Office Financial Policy:

Payment: You may choose from **Cash, Check, Visa, MasterCard, Discover Card, American Express, or Care Credit** Our office requires payment by the completion of your treatment. For extensive treatment plans, including Crowns, Implants, Bridges, Veneers, and Dentures, we require ½ down on the first visit for that procedure and the balance to be paid on or before the date of completion. There is a $35 service charge on checks returned as unpaid.

- **Patients without insurance coverage**
  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with Cash or Check for treatment plans of $500 or more. This courtesy can only be offered if the fee for the treatment rendered is paid in full on the day of service.

- **Patients with insurance coverage**
  Your insurance policy is a contract between you and your insurance. We are not always a party to that contract. We bill your insurance as a courtesy to you and will contact your insurance company on your behalf to receive a breakdown of coverage and provide them with necessary information to process your claim. The ***estimated*** co-pay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees associated with your treatment. Your insurance company determines final payment of your benefits. We cannot control what they determine to be final payment. All balances over 60 days become the responsibility of the patient.

- **Accounts that carry a balance**
  Outstanding balances greater than 90 days will be assigned to our collection agency. You are responsible for all fees associated with the collection of your overdue balance, including but not limited to: Collection agency fees, attorney fees, and any court costs incurred.

- **Scheduling**
  Your appointment is reserved especially for you based on your schedule and the time that you have available. *Two full business days notice is required* for rescheduling appointments. Please be considerate of our time as we strive to make ourselves available for your treatment.
  A $50 fee will be charged, depending on the amount of time that was reserved for you, and will be applied to your account for rescheduling, cancelling, or failing to show up for your appointment ***without two business days notice***. *Please contact us as soon as you know you will be unable to keep your appointment.*

I have read and understand the foregoing policies.

_____ _____

Please Print Name Signature

PLEASE COMPLETE BOTH SIDES OF THIS FORM ⇨