

PLEASE READ AND SIGN BELOW EACH SECTION

Payment is due in full upon services rendered

If you have insurance coverage, our staff will calculate estimated insurance payments for services rendered. We cannot, however, be responsible for the actual payment made by your insurance carrier. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

Signature of patient/parent/guardian

Date

COMMITMENT TO APPOINTMENT AGREEMENT

Your appointment time with the Doctor of Hygienist is reserved exclusively for you. An appointment with your name on it is a bond of trust that you will be present for that appointment and that we will be here to take care of your needs. Last minute changes in the schedule not only affect the doctor, but other patients as well. Many times we get calls from patients who are in pain and wish to be seen right away, which is difficult to do if we are booked. For this reason we cannot accept constant short-notice changes or cancellations. If you find that you cannot keep your appointment, kindly give us the courtesy of 48 hours notice so that we may fill the time with a patient who needs it. Any cancellations less than 24 hours notice or not showing are subject to be charged a fee of \$75 per hour for doctor's appointments and \$25 for hygiene appointments. We will accept recorded messages as appointment cancellations or changes as long as they are done 24 hours in advance.

A reminder call is given 1-2 days prior to your appointment time as a courtesy to our patients. However, you are ultimately responsible for all appointments made. The care and consideration of our patients is of the utmost importance to us. In return, we must ask for your consideration and respect for our time.

We value you as a patient and look forward to a long lasting and pleasant relationship with you. We appreciate your understanding and cooperation in this matter.

Signature of patient/parent/guardian

Date

FINANCIAL POLICY

Jupiter Dental Spa

1. I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest at the rate of 18% per annum (1.5% per month).
2. I hereby authorize my current insurance carrier to forward all medical payments on my behalf to Jupiter Dental Spa for any services furnished to me by the physician of this practice. I further authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This authorization will not be cancelled until further written notice, as this is a lifetime signature of Patient/Guardian. I understand that any amount not covered by my insurance company for ANY reason is my responsibility, and I, being the patient/guarantor, am solely responsible for the payment of any balance on my account. I further understand that if my account should be turned over for collection and/or legal action, I agree to pay for all collection fees including, but not limited to, postage, court costs, collection agency fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5% per month).
3. I authorize Jupiter Dental Spa to submit insurance claims on my behalf. I am aware that this service is being provided as a courtesy. I understand that I will be financially responsible for all services that are not paid in full within 90 days of service regardless of any reason given by the insurance company. At the point of 90 days past due, I agree to pay all costs of collection including, but not limited to: court costs, sheriff fees, collection agency fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5% per month).

Patient Signature

Date

WE ARE PLEASED THAT YOU HAVE DENTAL INSURANCE!

Your dental benefit program will assist you in obtaining and maintaining a superlative level of oral health.

Our office staff understands dental insurance and we'll be glad to assist you in obtaining the maximum benefits specified in your contract.

HOWEVER, IT IS IMPORTANT THAT YOU REALIZE:

1. Your dental benefit program is a contract between you, your employer, and the insurance company, **We are not a party to that contract.** This office files your insurance as a courtesy to you.
2. Our office generally, but not necessarily, falls within the usual and customary fee structure, determined by your carrier.
3. **Not all dental services are a covered benefit in all contracts.**
4. You (**not the insurance company**) are responsible to us for **all of our fees** for services rendered to you.
5. An **ESTIMATE** will be given detailing the benefits that the insurance company is expected to pay, and the amount that is expected from you at the time services are rendered.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care.

I have read and understand the above document and understand that any balance not paid by my insurance carrier is my responsibility.

Patient Signature

Date

PATIENT CONSENT FORM

The department of Health and Human Services has established a "Privacy Rule" to help ensure 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 operations.

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. 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 and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental 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. Those 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 actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to 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.

Print name

Signature

Date

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.