PREMIUM
FAMILY DENTAL

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____
Signature of Privacy Officer

6328 Richmond Hwy. #F, Alexandria VA 22306 | 703-765-0165 | FAX: 703-765-0166

APPOINTMENT POLICY

Your appointment time is reserved just for you. If you are unable to keep your appointment, please let us know 48 hours in advance so that we may schedule a new time for you. Failure to notify us may result in a $25 cancellation fee.

CONSENT FOR DENTAL SERVICES

I hereby request and authorize the dentist at Premium Family Dental and the dentist's auxiliaries to perform all dental treatment and surgery as indicated in my dental records and treatment plan. I understand and authorize for these procedures, which are deemed necessary and advisable in the dentist's judgment. I understand that some treatments such as Root Canals, Crowns, and Bridges/Partials may be split out in 2 visits. If I do not return to complete treatment within a month, it may be necessary to start treatment over again and I will be responsible for the entire treatment re-do cost. I also authorize the administration of drugs and anesthetics, as maybe deemed advisable by the dentist.

COUPONS & SPECIALS

On occasion, our practice offers discounts or coupons to help make dental care more affordable for non-insurance holding patients. Our $79 special is structured to help assist patients that obtain routine dental care every 6 months in maintaining optimal dental care. The $79 special covers a complete exam, simple cleaning, and 4 bite wing x-rays. This offer is not valid for patients who are diagnosed with periodontal disease by the dentist, as these patients require an intensive deep cleaning and a simple cleaning will not help and is not sufficient for the patient's oral health. The doctor will not perform the simple cleaning in these instances and an estimate for the type of cleaning needed will be provided.

DENTAL INSURANCE

Dental insurance is a contract between the employer and the patient. It has **NO CONNECTION** to the provider of dental treatment. The extent of the coverage varies from company to company, and sometimes even within a company. It has nothing to do with the level of service provided by the dentist and the fee charge for these services.
Although it is not required, we might prepare and submit your insurance claim forms at no cost as a courtesy to you. At your request, we might also provide estimates that show the expected insurance reimbursement and patient share for every procedure. This is only an estimate. You are ultimately responsible for the cost of all professional services rendered, regardless of the estimate, if insurance does not pay their portion.
I fully understand my financial obligation and responsibility to adhere to the appointment policy.

Date _____ Patient's Name _____

Patient/Parent/Guardian Signature _____