TOOTHOLOGIE

HIPPA NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability & Accountability Act of 1966 ("**HIPPA**"), every patient has the rights to privacy regarding their protected health information (**PHI**). The Notice of Privacy Practices describes how your doctor, out office staff ab dither outside of our office involved in your treatment & care, may use and disclose your PHI to carry out treatment, payment or health care operations and for any other use permitted or required by law.

> **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This may include communication of your health care with a third party (i.e. a physician or dentist to whom you have been referred, labs).
>
> **Payment:** Your PHI will be used, as needed, to obtain payment for provided services.
>
> **Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support business activities of our office, including, but not limited to, quality assessments and employee reviews, training, licensing and contacting you to confirm appointments.

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 achieve the very highest standards of ethics and integrity in performing services for our patients. We support your full access to your personal records & will release them upon request. We want to ensure that our practice never contributes to the growing problem of improper disclosure of PHI.

I, _____ (Patient Name), understand that as a part of my dental health care, **TOOTHOLOGIE** originates and maintains health records; by signing this consent, I authorize the practice to use and disclose my PHI to carry out treatment, payment and the day-to-day operations of the dental practice.

I have read, understand and agree to your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time.

I understand that I may revoke this authorization, at any time, in writing, understand that I cannot revoke actions that TOOTHOLOGIES has already taken, relying on a previously signed consent. I understand that TOOTOLOGIES has the right to refuse treatment should disclosure of PHI be refused.

I also authorize TOOTHOLOGIES to release PHI information/speak to _____

Concerning my dental treatment. Please fill out the contact info on BACKSIDE, unless left blank.

Patient Name (please print): _____

Signature:_____ **Date:**_____

Toothologie
8667 US Highway 42 Suite 100
Union Ky 41091

phone | 859-384-0393
fax | 859-384-0395

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I authorize **TOOTOLOGIES** to contact listed individuals regarding my treatment. I authorize the practice to release my PHI information, as deemed necessary, to listed individuals, in the event that I cannot be reached.

(Name 1):_____(Phone #):_____

Relation to Patient:_____

(Name 2):_____(Phone #):_____

Relation to Patient:_____

Signature:_____**Date:**_____

BELOW IS FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could NOT be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining

( ) Other (please specify)

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FINANCIAL POLICY

Insurance:

As a courtesy to our patients, we will submit claims to primary insurance companies for reimbursement of services rendered. **The estimated portion of dental fees and/or any applicable co-pays not covered by the primary insurance are due at the time services are rendered.** The patient portion of fees is an estimate only based on information provided to the office by the patient and insurance company. Any balance remaining after the insurance pays is the responsibility of the patient/guarantor. **It is the responsibility of the insured to understand his/her individual dental plan details including in-network/out-of-network status.** If you have a secondary insurance, we will submit the claim to the secondary insurance company on your behalf and arrange for reimbursement to be sent directly to the subscriber.

Initial _____

Financial Arrangements:

For our office to operate efficiently, we do not offer any in-office payment plans or monthly payment arrangements. We accept Visa, Mastercard, Discover, American Express, cash, check and all Health Savings and Flexible Spending Cards. If you require a monthly payment plan, our office accepts 'Care Credit,' and we participate in the 6-month interest free, and the 24, 36 and 48 extended month payment plans. If you would like information on Care Credit, please talk to one of our front desk staff.

Initial _____

Collections:

For us to cover our costs, all statement accounts are billed monthly and if an account becomes delinquent (over 120 days) and goes into default, the account will be assigned to a collection agency. The patient/guarantor is responsible for any and all collection agency fees. Returned checks are subject to a $25 fee.

Initial _____

I have read and understand the above financial policy. I understand that I am responsible for all charges regardless of insurance coverage or payment.

Patient/Guarantor name (please print): _____

Signature: _____ Date: _____

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SCHEDULING POLICY

We value the time of all our patients, and we make every effort to offer appointment times that are convenient for you.

Hygiene Appointments:

Appointments with the hygienist are 1-hour appointments for adults for a standard cleaning. For deep cleanings (scaling & root planning) or other circumstances, the appointment may take slightly longer. **When scheduling your appointment with the hygienist, please allow at least 1 hour for us to give you the best experience possible.** At the end of your appointment, you will be given the opportunity to schedule your next appointment in 3 months, or 6 months, depending on the type of cleaning needed. Please be aware that appointments that are at peak times (first in the morning, last in the afternoon, school vacation times & holidays) are the highest demand.

Treatment Appointments:

Treatment appointments with TOOTHOLOGIES vary in length. When presented with your treatment plan, you will be given an *estimated* out of pocket cost, which is due the day of service. For appointments that are longer than 1 hour, we request that a 50% deposit of your estimated out of pocket cost is paid on scheduling.

Cancellation Policies: Please refer to our Cancellation/NO-SHOW form.

Patient/Guarantor name (please print): _____

Signature:_____ **Date:**_____

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CANCELLATION/NO-SHOW POLICY

We understand that situations arise when you must cancel your appointment. However, when you do not call to cancel an appointment, you are preventing another patient from receiving treatment. As our patient, we will do our best to respect your time and hope that in return, you respect the time of our other patients as well.

We request that you give us at least 48 hours **BUSINESS DAY** notice for all cancellations. This means that calling Friday afternoon to cancel an 8am Monday appointment is not acceptable.

Patients who do not show up for their appointment without calling to cancel will be considered a NO-SHOW. Patients who arrive **15 minutes late** to their designated appointment time will be considered as NO-SHOW.

All cancellations with less than 48 working hours' notice and all NO-SHOWS will be subject to a **cancellation fee:**

- Hygiene appointments = $75 cancellation fee
- Periodontal and all restorative treatment = minimum $75 fee or % of scheduled treatment, depending on treatment planned and time scheduled

Patients who no show 2 or more times in a 12-month period will be expected to prepay in order to schedule all future appointments.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment; this fee will not be covered by your insurance.

We understand that special unavoidable circumstances (family emergencies, accidents, etc.) may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval.

Please understand that we strive to stay on time for your appointment as well as those patients that follow you. Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication.

I have read and understand and agree to this cancellation and no-show policy.

Patient name (please print): _____

Signature: _____ Date: _____

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CONFIRMATION SERVICES

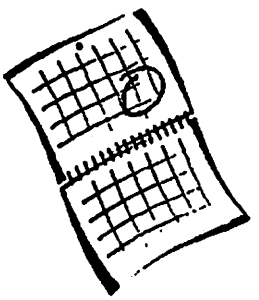
We offer *Lighthouse 360* to assist you with appointment confirmations. You will receive automatic reminders about your upcoming appointment, so you don't miss it!

Lighthouse 360 will send you a text and/or email; all you do is **reply "C" to confirm** your appointment!

You will also receive a text and/or email **24 hours** and **2 hours prior** to your appointment.

If you are not enrolled for this service, we will call you to confirm your appointment.

These services are in place for your convenience, so please utilize them! We thank you again for being a part of our patient family!



initials _____

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