HIPAA

The Department of Health and Human Services has established a "Privacy Rule" to help assure that personal health care information is protected for privacy. This rule was also created to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of personal health information (PHI) about the patient to carry out treatment, payment, or health care operations. We respect the privacy of your health care records and will do all we can to secure the privacy of that information. When it is appropriate and necessary , we provide the minimum PHI information about treatment, payment, or health care operations to essential indirect parties like labs. insurance companies, etc. You may refuse to consent to the use or disclosure of your PHI, 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 PHI. You may not revoke actions that have already been taken, which relied on this previously signed consent. You Also have the right to review our privacy notice, to request restrictions, and to revoke your consent in writing after signing this notice. We support your full access to your personal health records.

Insurance & Costs

Payment is expected at the time of service. Our fees may be different that what insurance covers. At times insurance reimbursements may be less, the same, or more than our private practice fees. Any balance not paid by insurance is the responsibility of the patient or guardian. Returned checks are subject to a $25 fee per check. I understand and accept the responsibility of payment due and payable at the time of service for dental services, therapeutics, or devices provided in this office for my dependents or myself. I will keep my commitments for these financial arrangements. I agree that if I become delinquent over 30 days on any arrangements, the remaining charges will become immediately due and payable in full. Charges shown by statement are agreed that up to 1.5% per month (18% annual) finance charge may be added to any balance for which no payment has been made for over 60 days. If sent to collections, there is around a $35 charge to cover those expenses. In the event of default on my part to pay the charges, I 9we) promise to pay legal interest on the indebtedness, together with such collection costs, reasonable attorney's fees, and other reasonable expenses incurred by the Dentist as may be required to effect collection of this debt. I also authorize payment directly to Dr. Paulette Soltis-Hamilton of ant benefits otherwise payable to me from my insurance company or dental benefit plan. I also understand that the office accepts CASH, CHECK, or CREDIT CARDS- American Express, Discover, Master Card, Visa, and Care Credit and that there will be an additional 3.5% fee on all credit card transactions over $300.

Appointments

Dr. Paulette Soltis-Hamilton and staff request all patients to acknowledge and actually confirm their scheduled appointments. Please be aware that Dr. Soltis-Hamilton's dental office is a small, two chair operatory family-oriented practice. Because of the need to accommodate issues that may arise with patients in a timely manner during the cay- some are on an emergent basis and for this reason we try as best we can to eliminate "no -shows."

We reach out to our patients approximately 2 weeks prior to your dental appointment via phone, text and email for your confirmation responses. Once you acknowledge any of our reach-out methods (or text back that you'll need to cancel), the notification systems will stop. If you do not respond up to approximately 2 business days prior, we will send you a "last message"- indicating that we will remove your appointment from the schedule by a specific time so that you do not incur a "no-show" fee. We will assume that after not hearing from you that you will be unable to make it to your appointment. Once an appointment is confirmed please remember that the time and resources have been reserved exclusively for you. If you fail to show or cancel without 24 hours notice, a minimum charge of $30 may be assessed. We will be lenient on the fist incident and will consider your reasons. This charge is based on time reserved for your appointment and covers lost overhead expenses of this office such as the salaries, utilities, rent, etc. These expenses must be paid whether or not you are present. We take your time very seriously and try our best to respect it, and in return we ask the same courtesy and consideration.

In regard to your own dental care, please be aware that we leave emergency contact information on our voicemail for existing patients during our off-hours in the event that you have a dental emergency. Dr. Soltis- Hamilton will return your call in a timely manner.

Thank you for your cooperation in keeping our practice running smoothly!

Patient Name (Printed): _____ Date: _____

Patient or Guardian (Signed): _____