Adeline W. Yuh, D.D.S., L.L.C.
SPECIALIST IN PROSTHODONTICS
414 CHATHAM SQUARE OFFICE PARK
FREDERICKSBURG, VA 22405
(540)371-0030
fax (540)371-1421 email: info@yuhprosthodontics.com

CONTRACT

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid thirty (30) days after services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned failed to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands the Dental Insurance claims may be billed by the provider, as a courtesy, if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that dental, personal, and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act".

_______________________________ _________________________

Patient/Guarantor Date

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OFFICE PAYMENT POLICY

We prefer not to send bills. That way we can concentrate on giving good dental care and not on collections.

Our policy is: Payment for dental services provided is due and payable at the time the services are rendered unless written financial arrangements have been made prior to the visit.

A 1.5% per month finance charge (18% annually) will be added to any balance over 30 days.

Appointment availability is very important to us and our patients. For this reason we request a minimum of 24 hours notice of cancellation or rescheduling of an appointment. Less than 24 hours notice will result in a $50.00 fee.

SPECIAL NOTE TO PATIENTS WITH INSURANCE

Dr. Yuh is not contracted with any dental insurance company networks.

Regardless of the insurance coverage, payment is due when services are rendered unless other written arrangements have been made. We will be happy to submit your claims and have the company reimburse you.

INSURANCE FACTS

Health insurance is a contract between a patient and an insurance company which agrees to pay certain prescribed benefits to the patient when health costs are incurred. Few dental insurance plans pay 100% of the costs. Get to know your insurance policy, what it does cover, and what deductibles you must pay first before other coverages will start, etc.

Although our office is recognized by most insurance plans as a provider of dental services, we are not a **participant** of any insurance plan. Consult your benefits booklet if you are unsure if you will receive benefits for treatment by a non-participating dentist.

Most insurance companies pay dental costs according to fee schedules which they have devised. The fee schedule may or may not coincide with the actual fees that are charged.

When requested, we will ask your insurance company for a predetermination of benefits they will pay for your treatment. When the predetermination authorization is received, we will discuss payment arrangements with you.

The insurance company has a responsibility to the patient according to the terms of the insurance contract. The patient has a responsibility to the doctor to pay for services rendered. Our policy requires that payments be made at the time the services are rendered unless a written financial agreement is made prior to the appointment.

We will be glad to help you with your insurance forms and assist you in getting payment from your insurance company.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, <<Pat_FirstName>> <<Pat_LastName>>, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature (You may refuse to sign this Acknowledgment)

____
Date

For Office Use Only

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

______ Individual refused to sign

______ Communications barriers prohibited obtaining the acknowledgment

______ An emergency situation prevented us from obtaining acknowledgment

______ Other (Please Specify)

____

____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (09/18/13), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use/sell your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. There will be no charge for the first copy. If you request additional copies, we will charge you $0.50 for each page, $15.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Breach Notification: We are required to notify you following a breach of unsecured patient information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Melanie S.
Telephone: (540)371-0030 Fax: (540)371-1421
E-mail: info@yuhprosthodontics.com
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HIPAA PATIENT COMMUNICATION FORM

It is office policy of Dr. Adeline W. Yuh not to release confidential medical information regarding your treatment to family members or friends except for:

(1) Parent/Legal Guardian
(2) other persons authorized by the patient
(3) as we may reasonably infer from the circumstances (for example, if you bring a family member into the exam room, we will assume, unless you object, that this person is entitled to receive information regarding your treatment
(4) in emergency situations, or
(5) other as other wise permitted by HIPAA 1996.

If you anticipate that you will need or want your medical information to be provided to family members, friend(s) or caretakers, please indicate that below so that we may best serve you. By signing below you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this IN WRITING to our staff.

Name: ____________________________________

Relationship:__________________________

Name: ____________________________________

Relationship: __________________________

Name: ____________________________________

Relationship: __________________________

Name: ____________________________________

Relationship: __________________________

Patient/Parent/Guardian Signature: __________________________Date: ______________