Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information and other important matters about your protected health information. A copy of our notice is posted in the reception area and accompanies this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, which will contain the changes, those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (423)813-7222.

Read carefully:
I have had the full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Further, I am giving my consent to release records and or discuss treatment, scheduling and payments with the individuals listed below.

Name _____ Relationship_____
Name _____ Relationship_____
Name _____ Relationship_____

♦ I attest to the accuracy of the information on these pages.
♦ I grant permission for you or to your assigners to telephone me at my house and/or work to discuss matters related to this form if necessary.
♦ I authorize release of necessary information to the insurance company.
♦ I authorize direct payment to my provider, Elizabeth Robbins, DDS, Michael Robbins, DDS, and Robbins Family Dental PLLC.

Signature indicates that I have read the above HIPAA Notice of Privacy Practices and agree to their content.

_____	_____	_____
Signature of Patient/Parent/Guradian/Guarantor	**Date**	**Relationship**

Financial Policy and Cosent for Services

We are looking forward to providing you with exceptional dental care. As a condition of treatment in this office, financial arrangements must be made in advance. This notice provides a description of our treatment, payment activities and healthcare operations. Our financial coordinator will be happy to assist you in any way possible.

Insurance: All dental services furnished are charged directly to the patient and he or she is personally responsible for the payment to the practice. Patients who have dental insurance understand that co-payment or deductible is due at time of treatment. This office cannot render treatment based on the assumption that our charges will be paid by the insurance company. The contract for insurance coverage exists between the patient and the insurance company that was chosen by the patient or the patient's employer, therefore we cannot force any insurance company to pay a claim. As a courtesy, this office will gladly file any insurance claims and will credit any such collections to the patient's account. However, if the insurance provider has not made payment within 60 days of treatment, the patient or responsible party must settle the balance immediately. Our office will then assist the patient in seeking reimbursement from the insurance company.

The patient may choose to pay for services in full and file their insurance for direct reimbursement. We will be happy to provide claim forms in such cases.

Third party financing: Our office gladly accepts all major credit cards. We also accept some third party finance companies that are specific for dental treatment such as Carecredit. We will be happy to provide the information needed to make your treatment affordable.

Emergency visits: (for patients that are not of record) we will be glad to provide emergency care for patients that have not had a comprehensive exam and regular care in our practice. However, all emergency dental treatment must be paid in full or sufficient insurance information given at the time of service.

Returned checks: there will be a $35 service fee for all returned checks.

Treatment warranty: We are proud to provide the highest quality dental care and products. Regardless of our best efforts, on very rare occasion dental material or restorations do incur problems. Please notify us immediately if you are having problems.

Our goal is to take great care of you! A warranty will be provided on dental restorations with the following guidelines:

♦ The patient must come to all regular cleaning and examination appointments as prescribed by the doctor.

♦ If the restoration fails within 1 year- 100% practice coverage
2-5 years- 50% practice coverage
After 5 years - 100% patient coverage

♦ If the tooth or restoration that was treated fails due to trauma or new decay then the warranty will be void.

♦ The warranty may be voided if special circumstances surround treatment (patient is informed)

Transfer/Copy of Records: It is State Law that dental office must retain the original chart and all x-rays for a period of 10 years from the date of service. If you need a copy of x-rays or other information from your record, a $25 duplication fee will be charged. Copies for specialist referral from this office are done at no charge.

Missed or broken appointments: Please give our office immediate notice if a change in your schedule occurs that will prevent you from coming to your scheduled appointments. We ask for a minimum 24 hour notice for change or cancellation. If more than two appointments are missed without 24 hour notice, then our office will ask that you place a $50 deposit before being seen.

Insurance Assignment: I authorize payment directly to the dentist and or dental group of insurance or insurance actual bill of services and that I am financially responsible for payment of my account in full by signing this statement revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by dental or payer. I understand that I am responsible for knowledge of my insurance plan and benefits coverage and for providing accurate updated information to this office regarding my policy.

Signature indicates that I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Signature of Patient/Parent/or Guardian/Guarantor	**Date**	**Relationship**