HIPAA

Healthy Family Dentistry

5350 W. Hillsboro Blvd., Ste. 201 Coconut Creek, FL 33073 Ph. #: (954) 708-2157

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: To whom may the information be released [name(s) or class(es) of recipients]:

2. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

3. Expiration date or event relating to the individual or purpose for the release:

General Rule-If you do not sign our consent form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule and Special Rules"), we can not in any matter use or disclose you PHI or any other information in your medical record. Under Florida law, we are unable to submit claims to payers under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing an Authorization, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____

Healthy Family Dentistry PA

5350 West Hillsboro Blvd Suite 201 Coconut Creek FL, 33073 (954)708-2157

Written Financial Policy

Thank you for choosing Healthy Family Dentistry PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- We also offer convenient Monthly payment plans[1] from Care Credit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please Note:

Healthy Family Dentistry PA requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. If insurance does not pay within 60 days, I agree to pay Healthy Family Dentistry PA the full balance. Any payment received by Healthy Family Dentistry PA after my balance has been paid, **will be refunded to me.**[2] I understand that Healthy Family Dentistry cannot be responsible for collecting my insurance claim or for negotiating a settlement on a disputed claim. I understand I am ultimately responsible for this account not matter what my insurance may or may not pay.

I agree to pay a fee of $25.00 for a check returned N.S.F.

Photographic Release (Optional)

I hereby authorize Healthy Family Dentistry PA to take photographs and slides of my face, jaws, and teeth. I understand that the photographs and slides will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising and in publications. I waive compensation, financial or otherwise , for the use of the photographs or slides. INITAL_____

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, your will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.