Discovery Dental Group

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____Initials:_____Reason:_____
_____

RADIOGRAPHIC IMAGES

Your optimum health is in our best interest. In order to provide you with all of the necessary information for you to make the best decisions regarding your health we must utilize dental radiographic images. The usual standard of care includes an updated full mouth series every five years and periodic images (usually four bitewings) taken once each year. I understand the importance of this diagnostic and treatment tool as well as the risks associated with not maintaining updated dental images.

Please initial one of the following:

_____I consent to all necessary dental radiographic images

_____I do NOT give consent to necessary dental radiographic images

DENTAL PHOTOGRAPHS

For most patients we recommend a series of dental photographs. We utilize photos to assist in patient education and also in treatment planning. Most photographs are of teeth only however we would like to have one face shot associated with your file. In some cases we may decide to reproduce, publish, or print such photographs.

Please initial one of the following:

_____I consent to the use of digital dental photography

_____I do NOT give consent to the use of digital dental photography

FINANCIAL POLICY

We are almost always able to work out a financial option for you to complete your dental treatment.

a) We offer a 5% discount for full cash payments at the time of service.
b) We take all major credit cards.
c) We offer a 3 month zero interest payment option. A 10% finance charge will be applied to all account balances over 90 days due.

Insurance:

As a courtesy to you, we will bill your insurance company and do all that we can to help you maximize any insurance benefit that you have. We view dental insurance as a "bonus" benefit that many patients unfortunately don't have. It should not dictate the type of treatment we offer nor should it dictate the type of treatment you choose to proceed with. Ultimately, services and treatment rendered you are your financial obligation and you, not your insurance company, will be held responsible for such.

_____ _____

Patient Name Date