

Notice of information and Privacy Practices
HIPAA Communication Form

Patient Name: _____

I have been given a copy of Professional Dental Alliance practice ("Practice"), Notice of Information and Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (724) 698-2500, or by visiting the Practice's web site.

Patient privacy is important to us. Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with concerning you or your child's health information and care. This includes family members, friends, organizations or caregivers and babysitters.

Name: _____ Relationship: _____
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

Patient Communication – Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other information via text message, email or via phone. Limited information will be left when leaving a voice message. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer we use an additional communication preference for appointment reminders or other information related to your care. You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices:

Patient or Guardian Signature

Date

Print Name and/or Personal Representative's Title (e.g., *Guardian, Executor of Estate, Health Care Power of Attorney*)

Financial Agreement

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All Patients must complete our "Patient Information Form" prior to being seen by the Dental Professional
- Full Payment is due at the time of Service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service.

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parent, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non – emergency treatment will be denied unless charges have been pre-authorized. Providers may choose to avoid treating a minor without an adult present at his or her own discretion.

Insurance

- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount maybe subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by the staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to us. However, if you are paid by the insurance company instead of us, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to an NSF fee of \$25.00

Patient or Guardian Signature

Date