



4600-D Pinecrest Office Park Drive | Alexandria, Virginia 22312
Office: 703-642-6425 | Fax: 703-642-2257

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the **Health Insurance & Accountability Act of 1996 (HIPAA)**. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessments and improvement activities.

I have been informed of my dental provider's **Notice of Privacy Practices** containing more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such **Notice of Privacy Practices**. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the **Notice of Privacy 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 healthcare operations. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Please Print Patient's (Last Name) (First Name) (Middle Initial)

(Signature of Patient/Parent or Legal Guardian) (Date)

Emergency Contact Name: _____ Emergency Contact Phone: _____

Authorized Release of Information

Please provide the name of an individual, *other than yourself*, with whom we have permission to share your appointment, billing, and dental information:

Name/Names: _____

Office Policy

Due to federal HIPPA Confidentiality Regulations, there will be **NO CELL PHONES** allowed in patient care areas. This includes phone calls, photos, videotaping and recording. Thank you for your cooperation and respect for our patients' and employees' privacy.

Financial Policy

Thank you for choosing our practice to serve your Oral Surgery / Dental needs. Please take the time to read the following, and sign/date the bottom of this form.

- Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.
- Insurance balances are ultimately the patient's obligation. We will file most primary insurances as a **courtesy**. However, insurances balance which are not paid within 60 days may be billed to you. Please keep your walk out statements and follow up with your insurance carrier to ensure prompt payment.
- Some of your treatment may not be covered by your insurance company. The fee for such charges will be your responsibility.
- Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.
- Patients are asked to confirm their appointments at least **48 hours** in advance by directly contacting our office or by responding to our confirmation contact.
- You will need to provide notice of **48 hours** for appointment time changes or cancellations to avoid broken appointment fee of **\$50-\$300**.
- There will be a fee of **\$30.00** for any checks returned as Non-Sufficient Funds (NSF).
- Patients balances that go unpaid for 30 days or more may incur one or more of the following charges:
Interest charges of 1.5% per month of 18% APR Collections fees (up to 42% of the full balance), Legal fees for collection services.

Signature of Patient or Guardian

Print Name

Date