

CONCERNING YOUR DENTAL PLAN

We feel our patients deserve the best possible dental care we can provide. In an effort to maintain this high quality of care, we would like to share with you some facts about your DENTAL PLAN.

PLEASE UNDERSTAND YOUR DENTAL PLAN DOES NOT "PAY ALL"

INSURANCE: As a courtesy to you, we participate in many insurance plans, but our professional services are rendered to you, not your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract. However, if insurance information is provided prior to your treatment and verification is obtained, we will accept assignment for the insurance portion of the benefits. Any portion of the fee not covered by your insurance is your responsibility. Patients are expected to pay the co-payment at the time services are rendered.

In most circumstances we will inform you of the cost of your next visit –if any- but please **DO NOT DEPEND ON THIS COURTESY.** *It is your responsibility to become familiar with your plan.* However, if any questions arise at the time of payment, our staff will be happy to discuss them with you.

In other instances your plan may not list a procedure which is necessary for treatment. In these cases our office charges our regular fee for that procedure minus the percentage indicated by your plan.

ALL PATIENTS ARE FINANCIALLY RESPONSIBLE FOR THEIR ACCOUNTS. We strongly suggest you become familiar with the provisions of your plan. We will cooperate in any way we can to help you obtain maximum benefits.

*****X-Ray Copy & Release *****

Requested x-rays taken here in our office will be subject to a charge of \$35.00, no exceptions.

X

Patient's Signature

Date

NOTE: We would like to remind you that there is a fee of \$25.00 for BROKEN APPOINTMENTS. Cancellations must be made 24 hours in advance in order to avoid this charge. Thank You.

OUR FINANCIAL POLICY

Thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

***Full Payment is due at time of service.**

***We accept Cash, Visa, MasterCard, Discover, and American Express.**

*** We offer no interest & extended payment plan with prior credit approval thru Care Credit.**

Regarding Insurance:

We do accept assignment of benefits; however you are responsible for your percentages up front. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, as a courtesy to you we bill your insurance. If your insurance has not paid within 45 days, the balance will automatically be billed to you.** Please be aware that some and perhaps all, of the services provided may not be covered by your insurance, we do our best to find out this information beforehand, and do our best to give you your estimated fees, but sometimes the insurance does not pay even when we've been told they will, this then does becomes your responsibility.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Non Sufficient Funds:

There will be a \$35.00 handling fee for any nonsufficient funds checks.

Minor Patients:

The parent or guardian of the minor patient will be responsible for the patient's bill.

Missed Appointments:

Unless canceled, at least 24 hours in advance, our policy is to charge for missed/broken appointments at the rate of \$25.00, per hour of your scheduled appointment. Please help us serve you better by keeping scheduled appointments. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Date _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person (s) to have access to information covered under the Privacy Practice regarding myself.

Please Print Name	Relationship
Please Print Name	Relationship
Please Print Name	Relationship

Authorization for Treatment

I hereby authorize Dr. Sy Tangco, or a dentist designated by her, and whomever she may designate as assistant to render dental treatment to me. I consent to care and to treatment that may encompass laboratory, diagnostic, or medical treatment that my Doctor or her assistant may deem necessary for my health and my wellbeing.

Signature of Patient	Date
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Signature of Parent/Guardian	Date
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Apopka Dental Art Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Apopka Dental Art, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (<http://www.hhs.gov>) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Dr. Sy Tangco, at (407) 886-8817 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the Apopka Dental Art Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____