PRAST FAMILY DENTAL

BILLING AGENT AUTHORIZATION AND FINANCIAL POLICY

PLEASE READ THIS FORM CAREFULLY

Patients with dental benefits:
Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. It is ***your*** responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for **all** costs incurred. Please remember that your insurance policy is between you and your insurance company and not your insurance company and your dentist. Although we fill out and submit insurance forms as a courtesy to you, the claim is subject to eligibility, plan maximums, reasonable and customary reductions, deductibles, non-duplication clauses, prior authorization and referral requirements, remaining benefits and other items that can affect claim payment.

Patients without dental benefits / "self-pay":
Payment for all dental treatment is due in full at time of service.

******The patient is ultimately responsible for payment of services rendered******

Thank you for your cooperation and understanding

I have read and understand the above statement:

_____
Print Name

_____ _____
Signature of patient or patient representative Date

_____
Witness (Business Associate)

PRAST FAMILY DENTAL
PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment to other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (e.g., my insurance company);
- The day-to-day healthcare operations of your practice

I request that all communications to me regarding appointments to be handled in the following manner:

E-Mail Reminders? (Please list email) _____
Text Reminders? (Please list phone number) _____
May we leave a message on an answering machine? _____
May we leave a message with a family member? _____
May we call you at work? _____ Phone Number_____

I give permission for the practice to discuss my treatment and/or financial information with: my spouse_____ parent/guardian _____

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment on health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name _____

Signature of Patient or Representative _____

Relationship to patient (if other than patient) _____

Witness (Practice Representative) _____