HIPAA CONSENT

Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all of part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature: _____ Print Name: _____ Date: _____

Compliance Assurance Notification For Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Please Complete Both Sides

ROCK STREET PEDODONTICS
PEDIATRIC DENTIST


Office Policy Statement

Childs Name: _____

PLEASE BE SURE TO READ EACH POLICY THROUGHLY. YOUR SIGNATURE IS REQUIRED AT EACH AREA INDICATED BY THIS SYMBOL: **X**

1) OFFICE ACCEPTANCE CONSENT: "I UNDERSTAND THAT THE INFORMATION PROVIDED ON THIS FORM IS ESSENTIAL TO DETERMINE MY CHILD'S DENTAL NEEDS AND THE PROVISIONS OF DENTAL TREATMENT. I UNDERSTAND THAT IF **ANY CHANGE** OCCURS IN MY CHILD'S HEALTH, I AM TO REPORT IT TO THE DENTAL OFFICE. I HAVE READ AND UNDERSTAND EACH QUESTION AND HAVE ANSWERED ALL OF THEM TRUTHFULLY, AND TO THE BEST OF MY ABILITY. I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURES INCLUDING DENTAL RADIOGRAPHS, EXAMINATION, DENTAL PROPHYLAXIS, TOPICAL FLOURIDE APPLICATION AND/OR ANY TREATMENT AS MAY BE NECESSARY FOR MY CHILD'S PROPER DENTAL CARE".

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

2) INSURANCE AUTHORIZATION AND PAYMENT/FINANCIAL POLICIES: "I AUTHORIZE MY INSURANCE COMPANY TO PAY DR. DANIEL GONZALEZ ROCK STREET PEDODONTICS, AND I UNDERSTAND THAT MY DENTAL CARE INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. IT IS THE INSURANCE HOLDER'S RESPONSIBILITY TO KNOW THEIR COVERAGE AND BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENTS IN FULL ON ALL ACCOUNTS".

IF YOU HAVE DENTAL INSURANCE, YOUR DENTAL CLAIMS WILL BE PROCESSED AS FOLLOWS:

- IN NETWORK – IF THE DENTIST IS A PARTICIPATING PROVIDER WITH YOUR INSURANCE, YOU WILL BE BILLED PURSUANT TO THE TERMS OF YOUR DENTIST AGREEMENT WITH YOUR INSURER.
- OUT OF NETWORK – IF THE DENTIST IS **NOT** A PARTICIPATING (OR IN NETWORK) PROVIDER WITH YOUR INSURANCE PLAN, WE WILL SUBMIT DENTAL CLAIMS TO YOUR INSURER, **AS A COURTESY**. IF YOUR INSURANCE CARRIER WILL NOT ACCEPT ASSIGNMENT OF BENEFITS TO YOUR DENTIST, **YOU ARE RESPONSIBLE** FOR ANY AND ALL COST INCURRED, NOT COVERED AND PAID BY YOUR INSURANCE COMPANY.

IF YOU HAVE ANY QUESTIONS RELATED TO YOUR INSURANCE COVERAGE, WE ENCOURAGE YOU TO CONTACT YOUR INSURANCE COMPANY DIRECTLY. IT IS YOUR RESPONSBILITY TO NOTIFY THE OFFICE **IMMEDIATLEY** IF THERE ARE ANY CHANGES TO YOUR INSURANCE PLAN OR ANY LAPSE IN COVERAGE. IF FOR ANY REASON YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR COLLECTION ATTORNEY, THE RESPONSIBLE PARTY AGREES TO PAY.

ALL FEES CHARGED BY THE AGENCY OR ATTORNEY, **IN ADDITION** TO THE FEES OWED FOR SERVICES PROVIDED BY THE OFFICE

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

3) KIDS MUST BE ACCOMPANIED BY PARENT OR LEGAL GUARDIAN

4) MISSED APPOINTMENT POLICY: "I UNDERSTAND THE OFFICE REQUIRES AT LEAST 24 HOURS NOTICE FOR ALL APPOINTMENT CANCELLATIONS. IF I AM UNABLE TO PROVIDE 24 HOUR NOTICE, I WILL BE BILLED A $25.00 CHARGE FOR MY SCHEDULED APPOINTMENT TIME". WE OFFER AN AUTOMATED COURTESY CALL THREE DAYS PRIOR TO YOUR APPOINTMENT. YOU ARE RESPONSIBLE TO REMEMBER YOUR APPOINTMENT IT IS NOT THE OFFICE RESPONSIBLILTY TO REMIND YOU.

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

Please Complete Both Sides