DENTAL SPECIALTIES of West Chester
FOR ALL YOUR DENTAL NEEDS

HIPAA Consent

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 about treatment, payment, or health care operations, in order to provide health care that is best for you.

We also want you to know that we support your full access to you personal dental records. We may have indirect treatment relationships with you, such as laboratories that only interact with doctors and not the patient, and may have to disclose personal health information for purposes of treatment, payment, or health care options. 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 you should you choose to refuse to disclose your Personal Health Information (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 our 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.

X_____ _____

Sign Patient Name Date

Financial Policy

In our continued commitment to provide the highest quality of dental care available to all our patients and to have those services comfortable affordable, we are pleased to offer you these options for payment:

- Cash or Check
- Visa, MasterCard, American Express, or Discover
- 50% at preparation and 50% at cementation or final impression appointment
- Dental Fee Plan or Care Credit
- A financial arrangement previously approved by a patient coordinator prior to treatment

We are committed to supporting you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation. We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier. Please remember having dental insurance is not a guarantee of benefits and treatment submitted may be subject to review.

I agree that I am responsible for the total payment of all procedures performed in this office, and this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within ninety (90) days of date of service, regardless of whether or not insurance benefits have been received. One percent (1%) per month interest (12% per year) will be charged on accounts after 90 days from treatment date. If further actions are taken to satisfy charges, additional administrative fees will apply.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience with us.

X_____ _____

Sign Patient Name Date

X_____ _____

Sign Patient Name Date