Pamela A Nicoara DDS MSD PLLC

PERIODONTOLOGY • IMPLANTOLOGY • ORAL MEDICINE

Acknowledgement of Receipt of Privacy Rights

Patient Name
Date

I am aware that in order to help protect against identity theft, my photograph will be taken at my initial visit in compliance with the Federal Trade Commission's Identity Theft Red Flags Rule (16 CFR 681.2).

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's Statement of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate treatment among health care providers who may be involved in my care
- Obtain payment from third-party payers for my health care serviced
- Conduct normal health care operations

I have been informed of my dental providers Statement of Privacy Practices containing a 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 Statement of Privacy Practices. I understand that my dental provider has the right to change the Statement of Privacy Practices and that I will be offered a current copy of the Statement of Privacy Practices at the time of my first visit after the changes become effective.

I understand that I may provide a written request asking my dental provider to restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that my dental provider is not required to agree to my requested restriction, however, if my dental provider agrees, then my dental provider is bound to abide by such restrictions.

Additional Disclosure Authorization:

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating a checkmark in answer to each individual question, personal protected (PHI) cannot be shared with anyone other than me unless otherwise allowed by HIPAA rules.)

-Please see front desk to fill out electronically-

Personal Health Information can be shared with:

- ☐ Spouse only (Name: _____, Phone number: _____)
- ☐ Any Immediate Family (Spouse, Children, Children's Spouse)
- ☐ Any Extended Family (Parents, Grandchildren)
- ☐ Other (Name: _____, Phone number: _____)

Name of signer if other than patient: _____

Relationship to patient if other than self: ☐ Spouse ☐ Parent ☐ Sibling ☐ Child

Which method of communication do you prefer from our office: ☐ Phone ☐ Email ☐ Text

-Please provide the front desk with the best phone or email address you want us to use-

---

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:

- ☐ Patient refused to sign
- ☐ Physically unable to sign
- ☐ Emergency situation
- ☐ Patient needed more time to review
- ☐ Communication barriers
- ☐ Other: _____

... Please Turn Over ...

Office and Financial Policies

UPDATED 5/23

Patient Name
Date

Outstanding Patient Service is Our Goal

The goal of Dr. Pamela Nicoara and the staff is to make sure that you receive the highest quality dental care and service. One step is to make certain our financial policies are clear and understood by you.

Insurance

We are not contracted with any dental or medical insurance carriers, therefore, you will be responsible for paying all charges at the time of service. However, we will file all dental claims on your behalf and provide any information required by your insurance carrier so that you will be reimbursed by your insurance carrier directly.

Your payment is due at time of treatment

We accept Debit cards and Credit cards (Visa, MasterCard, Discover, and Care Credit). Care Credit is a medical credit card which provides up to 12 months no interest payment option through our office.
We do not have post-treatment payment plans, but you can make pre-payments towards your care in advance.
We do not accept cash or checks.
For treatment with an out of pocket estimated over $5000, 50% of the balance is due at the time your appointment is scheduled. For treatment expected to last 3 hours or longer or that involves IV sedation, a $500/hr late cancellation fee deposit is due at the time your appointment is scheduled, which is credited toward your balance, but which is non-refundable if you cancel with less than 48 hours business days notice outside of extreme circumstances. You can pay your bill online securely via our website.

How we will communicate with you

I understand that I will receive communication from this office either directly from the staff via a phone call, or through HIPAA compliant secure encrypted email via 'Protected Trust' or 'Solution Reach Reminders'.

Cancellation, Confirmation and Tardiness Policy

We understand circumstances arise that prevent patients from keeping appointments. However, we ask you give a minimum of 48 hours business days notice if you need to make any change for non-surgical appointments. Normal business hours are Monday-Wednesday 8am to 4pm, and Thursday 8am-12m. Since we are closed Friday through Sunday, Monday 8am cancellations require notice by Wednesday 8am the prior week. This allows us the opportunity to give another patient this valuable time. A fee of $90/hr of your scheduled examination appointment will be assessed when 48 hours business days notice is not given. This fee may be waived if it is your first missed appointment, and if we can fill the empty appointment space, provided you also re-schedule your appointment. Confirmation is required no later than 48hrs prior to your appointment. You will get a reminder several days in advance to confirm. If we do not hear from you at 48hrs, your appointment can be cancelled and you can be charged the $90/hr cancellation fee for non-surgical appointments. The fee is $180/hr if you simply do not show up, and $300/hr for surgical appointments. You should arrive 10 minutes prior to your appointment. Surgical appointments require 1 week notice, and you will get a reminder 1 week in advance.

Patient Responsibility, Assignment and Release

I accept financial responsibility for all services regardless of any insurance coverage. I understand my responsibility is not modified by whether insurance pays for any of the charges. I understand that my portion of this account becomes delinquent if not paid 30 days after billing and that at that time a finance charge of 1.5% of the unpaid balance will be charged every month for 6 months until the balance is paid in full, after which time you may be sent to collections. I authorize release of any medical care information requested by my insurance carrier.

-Please see front desk to sign electronically-
Signature

… Please Turn Over …