Pamela A Nicoara DDS MSD PLLC

PERIODONTOLOGY • IMPLANTOLOGY • ORAL MEDICINE

Acknowledgement 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

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 go the Extra Mile

If you have dental insurance, we will make a good faith estimate of the amount your insurance carrier may pay for initial examinations, deep cleanings and surgery based on the information provided by them, and will defer billing you for that amount for up to 90 days. We are not able to continually verify insurance coverage for routine cleaning appointments, and any amount due is your responsibility. We are not a Participating Provider with medical insurance carriers, and therefore, you will be responsible for paying all charges at the time of service except that portion estimated your dental insurance carrier may pay. We will file all dental claims noted above on your behalf as well as provide any information required by your insurance carrier to ensure it is processed in a timely manner. We will follow-up with your dental insurer when claims listed above are not processed in a timely manner and attempt to expedite payment. We are also happy to provide your insurance carrier with x-rays or other information they may require.

If your insurer denies coverage, or if we otherwise do not receive payment within 90 days from filling your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.

Your payment is due at time of treatment

The amount estimated to be your portion of treatment is due at the time of treatment. We accept Debit cards, Credit cards (Visa, MasterCard, Discover, and Care Credit). We do not accept cash or checks. For treatment estimated over $6000, 50% of the balance is due at the time your appointment is scheduled. We also offer a 90-day no interest extended payment plan for balances over $1000.

We offer a 5% senior discount if you are over 65 years of age.

Patient Responsibility

I acknowledge my responsibility for payment of the services received from Pamela A Nicoara DDS MSD in accordance with their regular fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none 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 charge every month until the balance is paid in full.

Cancellation and Tardiness Policy

We understand that sometimes circumstances arise that may prevent patients from keeping appointments. However, we ask that you give us a minimum of 48 hours business days notice if you need to make any type of appointment change for appointments less than 2 hours. For appointments greater than 2 hours, 1 week notice is required. You will get a reminder 2 weeks in advance. Normal business hours are Monday-Wednesday 8am to 5pm, 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 with one of our dental care providers. A fee of $75/hr of your scheduled appointment will be assessed when 48 hours business days notice is not given for missed appointments. This fee can 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. A fee of $5 per minute may be assessed if you are late for your appointment as you should arrive 10 minutes prior to your appointment.

Assignment and Release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance carrier.

-Please see front desk to sign electronically-
Signature

… Please Turn Over …