

MY Dentists
Consent for Use and Disclosure of Health Information

Print Name _____ DOB: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare, operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available on our website. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices; we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager of MY Dentists
Telephone: 704-375-8577 Fax: 704-331-9987
Address: 411 Billingsley Road, Suite 102 Charlotte, NC 28211

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Please list any persons you wish to have access to your account: (All areas of account will be accessible, unless documented below.)

SIGNATURE _____ **DATE** _____

If not Patient, Print Name and Relation: _____

MY Dentists Financial Policies and Release of Information

Thank you for choosing MY Dentists for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist in cost of dental care.

As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us accurate and up-to-date insurance information.

- Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made.
- We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, AMEX, and Care Credit.
- Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.
- Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.
- We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed.
- We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days.
- Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all cost before treatment is administered. If special arrangements are needed, please talk to our financial manager prior to receiving service.
- Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments: Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment please notify us (even after hours) at least 24 hours in advance. Failure to notify us less than 24 hours before your appointment may result in a minimum broken appointment charge of \$42.00.

Returned Checks: For checks returned to us, as unpaid by your bank, we will charge you a \$35.00 fee.

Past Due Accounts: Overdue accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform MY Dentists of any changes associated with my insurance status. I agree to make an in-full, prompt payment to MY Dentists when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to MY Dentists.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

MY Dentists has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature: _____ Date: _____