HIPAA- Consent for Use & Disclosure of Health Information:

To The Patient: Please read the following statements carefully. 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 out 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. We encourage you to read it carefully and completely. We reserve the right to change our policy practices as described in out Notice of Privacy Practices. If we change our policy 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.

Appointment Commitment:

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reservation with us. If circumstances arise and it becomes necessary to change your scheduled appointment, we ask that you give us at least 48 hours' notice. A broken appointment; one in which a patient does not call or show up, is not acceptable. If you have an appointment and do not show up or call to inform us of an emergency; you may be required to place a $50.00 deposit to reserve another appointment and/or be charged a no show fee of $50.00. We also reserve the right to limit your reservations to same day opportunities for any future appointments.

Insurance/Finance Policy:

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of their total dental investment. As a courtesy to our patients, on the date of service, we will submit all necessary claims to their insurance. We will only collect monies for the amount we ESTIMATE your insurance will not reimbursing us; however the total dental investment is your responsibility. It is also your responsibility to contact your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days, regardless of insurance, is due in full. Any unpaid balance is subject to interest, at an interest rate of 1.5% per month.

It is your responsibility to complete treatment and follow the recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your overall health. If you do not proceed with your treatment plan in a timely manner, further treatment on the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints may be adversely affected.

Importance of patient awareness regarding insurance benefits:

We realize how important insurance benefits are and ask that you carefully review your policy and/or contact your insurance carrier so you are aware of deductibles, benefits, frequency limitations, and/or other restrictions. Please be informed that dental insurance is a contract between you and your insurance company; our role is to assist you with filing your claims. Your dentist will provide the highest quality of care, regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly allowance (maximum) and anything over that amount will be your responsibility. If you have two insurance policies, please be aware of both policies - not all secondary policies will cover remaining portions. Your insurance provides a copy of an Explanation of Benefits (EOB) to you. Please pay attention to these statements. At your first visit or at the time of dental coverage changes, please provide us with a copy of your insurance card and benefit booklet (if available). It is your responsibility to update us with any changes to your insurance. If dental services have been provided with another provider within the existing benefit year, please advise us, so we can account for the previously used benefits.

Collection Policy:

I understand that if I do not pay my account with The Reno Dentist that my account may be assigned to a collection agency.

I understand that if my account is assigned to a collection agency that the collection agency will charge a collection fee as much as 35% of the amount I owe to The Reno Dentist. I understand that if my account is assigned to a collection agency, I will be responsible for the amount due on my account and the additional fee charged by the collection agency, and that the addition of a collection agency's fee to my unpaid balance will result in my owing a sum substantially greater than the amount owed for dental services.

- For example, in such event; if the unpaid balance is $150, the added fee may be up to $52.50, and the sum I would be responsible for would be $202.50.

I understand & agree to the aforementioned policies.

Your will be asked to sign these consents electronically at your appointment.