COLUMBUS DENTAL CARE, PLLC

HIPAA Notice of Privacy Practices

Office Financial and Dental Insurance Policy

Patient Name:_____ Date:_____

HIPAA Notice of Privacy Practices Columbus Dental Care PLLC is required by law to maintain the privacy of your dental information and provide patients with our HIPAA - Notice of Privacy Practices. This form is a notice of our legal duties and privacy practices with respect to your Public Health Information. The signature below acknowledges receipt of a copy of the HIPAA Notice of Privacy Practices, and grants to clerical/clinical staff permission to release health and/or financial information to a family member, friend, or other person to the extent necessary to help with your healthcare, or payment of your healthcare, unless otherwise noted.

List person(s) NOT ALLOWED ACCESS to your health or financial records on the line below:

_____

Office Financial and Dental Insurance Policy

All patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and patients are personally responsible for payment of all dental services. Columbus Dental Care PLLC will help prepare the patient insurance forms and/or assist in making collections from insurance companies, and will credit any such collections to the patient's account. Fees generated by Columbus Dental Care PLLC providers are not governed by the provisions of patient insurance policies. Our office is not responsible for collecting your insurance payment or negotiating settlements on disputed claims. Each patient - not the insurance company - is responsible for payment of their bill.

Patient payment is due at time of service. I authorize the release of any dental information necessary to process claims for services provided; and authorize payment of dental benefits to Dr. Joseph Columbus. The signature below acknowledges receipt of a copy of the Office Financial and Dental Insurance Policy and agreement with its content.

Consent for Services

I hereby voluntarily consent to dental treatment as deemed necessary by the doctors of Columbus Dental Care PLLC. I understand that it is a policy of the practice to contact patients by phone, email, or text to remind them of appointments. I grant permission to Columbus Dental Care PLLC to telephone me, at any number provided, to discuss matters related to my treatment.

I acknowledge that if I arrive more than ten minutes late, my appointment may be void and may need to be rescheduled at the discretion of the office, and if I fail or cancel short notice (less than 24 hour), I may incur a $50 appointment fee for the lost time.

The signature below acknowledges consent for services provided by Columbus Dental Care PLLC providers.

X _____Signature (or parent/guardian if patient is a minor)