Elite Dental Group Inc.

HIPAA Form

RECORDS RELEASE

Records will be released to doctors we have referred you to at no charge; however, if you are requesting your records be transferred to another dentist for any other purpose, there may be a $35 charge. You will also need to sign a records release form. These forms are available through us or another dental provider.

Initials _____

PRIVACY PRACTICES

Elite Dental notice of Privacy Practices is posted in the office waiting room, and on our website. Hard copies are also available for all patients. In accordance with the HIPAA privacy act, all patients are required to acknowledge receipt of the notice of privacy Policies.

Initials _____

ACKNOWLEDGEMENT

By signing this form, I acknowledge receipt of Elite Dental Group Policies and notice of Privacy Practices. I understand that the Notice of Privacy obtains information on the uses and disclosures of any personal health information, and I have been given the opportunity to review the Notice. I understand that the terms of the Notice may change and that I will be given a revised notice if changes occur. I understand that I may request restrictions on the uses and disclosures of information for the purpose of treatment, payment, or dental care operations. I understand that Elite Dental Group is not required to agree to such request, but that if they do agree, those restrictions are binding to Elite Dental Group.

Initials _____

CONSENT

I authorize Elite Dental Group dentist and hygienists to examine, take radiographs, study models, photographs, and/or any other diagnostic aids deemed appropriate and necessary, and perform treatment and therapy that may be indicated in connection with my (or my child's) dental care. I also understand that the use of anesthetic agents embodies certain medical risks.

Initials _____

SCHEDULING

I authorize Elite Dental to leave a voicemail, send an email and /or send text messages to the phone/email provide on the new patient forms for the purpose of appointment scheduling and reminders.

AGREEMENT TO PAY FOR TREATMENT

I understand that I am responsible for payment of all dental services provided in this office (whether or not insurance or third party payer is involved) and that payment is due at the time services are rendered. If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge, or interest will be added to my account. The billing charge will accrue at the rate of 1.5% per month, which is an annual percentage rate of 18% (or a minimum charge of $5.00). In case of default payment I agree to pay any and all cost in collection this account, including but not limited to reasonable attorney's fees and court cost. I also understand the office policy is to require a minimum of a one business day notice for all cancelled/rescheduled appointments. If this is not possible, a fee of $40.00 that is not reimbursable by insurance may be charged to my account.

_____ _____

Patient/Guardian's Signature Date

INSURANCE

As a courtesy to our patients, we will prepare and submit your insurance forms for reimbursement. We cannot obtain payment, however unless you provide us with all the necessary information as requested above. Additionally, please understand that your insurance is a contract between you/your employer and the insurance company. We cannot in any way guarantee benefits or payment from your carrier, nor can we know the specifics of every individual plan. It is your responsibility to know the terms and limitations of your Insurance plan.
Please read and understand that by signing, you are agreeing to the following:

- I authorize my insurance to pay the doctor directly all insurance benefits otherwise payable to me.
- I authorize the doctor to release any information including, but not limited to, records of treatment, or examination, person identification, x-rays, medical history, etc. To my insurance company as requested.
- Any estimates given with regard to treatment fees are only rough estimates based on limited information we have about your plan.

_____ _____

Patient/Guardian's Signature Date