FINANCIAL & HIPAA POLICY

1. Charges for services rendered are due and payable the day of the appointment.
2. We accept payments in the following forms:
   Cash, Credit card, Personal checks, and Financing options (Care Credit)
3. It is your responsibility to provide us with **correct information** relative to your claim; including insurance card, ID number, employer, birth date, address, and social security number. Please notify us of any changes immediately.
4. **We will assist with filing insurance; however, the Patient, Parent, or Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company.** When treatment co-pays are quoted by the office, these are only estimates; your actual insurance coverage may be less or more.
5. Personal checks that are returned due to “insufficient funds” are subject to a $25.00 service fee.
6. **Appointment cancellations with less than 48 hour notice are subject to a fee of $50.00.** After 3 broken appointments, we reserve the right to terminate our patient/doctor relationship.
7. All accounts over 60 days will be considered past due and are subject to a $25.00 billing charge. Past due accounts maybe referred to an authorized collection agency. Accounts sent to a collection agency will be assessed a $15 collection fee or 33.3% collection charge on the unpaid balance, whichever is greater. The patient, parent, or guardian will also be liable for any applicable attorney fees and court costs.

I have read and understand the Financial Policy of Oronoco Dental. I agree to be responsible for all dental services and materials not paid by my dental insurance for me and/or my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to Oronoco Dental, unless payable to me directly per the insurance plan.

________________________________ ________________________ ____________

Signature of Patient/Parent/Guardian of minor Print Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

We use and disclose the information we collect from you as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone -even family members- without your written consent. We will only request personal information needed to provide our standard of quality dental care, implementing payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

As stated above, we may disclose your information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointment including voicemail messages, text messages, and postcards.

My signature confirms that Oronoco Dental has provided me access to a copy of its HIPAA Privacy notice which explains how my health information will be handled in various situations. By law, we are required to have you sign this form on the first visit with Oronoco Dental. I have been informed of my rights and to privacy regarding protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly and indirectly
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations such as quality assessment and improvement activities

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________________ Date:________________________

Signature: ____________________________________

Relationship to patient: ___________________________

Dependent family members also covered by this acknowledgement: ________________________