CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign This Acknowledgment

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, 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 at your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our 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.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care:
(Example: Spouse or Parents) _____

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.

Print patient Name-_____ Date of birth-_____

(Print Parent or Legal Guardian name if patient is a minor)- _____

Signature Date-_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt or acknowledgment of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barrier prohibited obtaining acknowledgment

☐ Other (Please Specify)

_____

Financial Policies

In order to accommodate the needs and requests of our patients, Dental Resort does file dental insurance. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all individual requirements of each plan. Dental benefit plans will never pay for completion of your dental care; it is only meant to assist you. We are not contracted with all insurance companies. It is the insured person's responsibility to understand their benefits and confirm that our dental providers are in their network. Dental Resort can only provide an ***estimate*** of what your insurance will pay on a specific treatment and it is not a guarantee of payment. Secondary insurance can also be filed for our patients; however secondary insurance benefits are not taken into consideration when estimating coverage. If your insurance carrier pays a lesser amount than estimated, you will be billed for the difference.

Please initial on each line.

_____All co-payments, estimated co-insurance, and deductibles are due at the time of service, or before your procedures. We accept cash, check, all credit cards and outside patient financing. Any check dishonored by your bank will result in a $35.00 returned check charge added to your account.

_____If your insurance company does not pay within 60days, Dental Resort reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you.

_____It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of active insurance at your visit, you will be considered a self-pay patient for that visit and payment will be due in full that same day.

_____It is your responsibility to provide us with any legal documentation or divorce decree dictating a specific parent/guardian responsible for primary dental coverage.

_____If you do not inform us of any special requirements in your insurance contract, such as referrals or per-authorization for treatment and we subsequently complete services that are not covered, you will be billed directly for those charges.

In the event your account is turned over to an outside agency for collections, you will be responsible for all collection fees, cost and such additional sums as the court may adjudge responsible.

Our team members will gladly assist you in filling out necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Dental Resort.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Signature (Parent if Child) -_____

Date-_____

Broken Appointment Policy

We attempt to make confirmation calls, send texts, as well as emails at least 48 hours in advance of your scheduled appointment as a courtesy. We will leave reminder messages on your answering machine if you have one. Therefore, we ask that our patients kindly give us a 24 hour notice if there is a need to cancel or reschedule an appointment. A one-time consideration will be made for failure to give notice. Any cancellation or no shows after that will be charged a **$25.00 fee.**

Thank you for your understanding of this matter, as we strive to provide the best quality care for our patients.

I have read the above Broken Appointment Policy, and I understand that I will be charged if I fail to show up for my scheduled appointment.

Patient Name (Printed)-_____

Patient Signature (Parent if Child)-_____

Date-_____

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. Shawn Nemovi DDS, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient) _____ Date _____