# Notice of Privacy Practices

## Patient Acknowledgement

Patient Name: Date of Birth:

*I have been given the opportunity to receive IMAGECARE'S Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by IMAGECARE, my individual rights and the IMAGECARE'S legal duties with respect to my protected health information. These include, but are not limited to the following:*

» A statement that IMAGECARE is required by law to maintain the privacy of protected health information.

» A statement that they are required to follow the terms of the notice currently in effect.

» Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.

» A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.

» A description of uses and disclosures that are prohibited or limited by law.

» A description of disclosures that require my written authorization and how I may revoke authorizations.

» My individual rights with respect to protected health information and how I can exercise those rights in relationship to:

» The right to complain to IMAGECARE and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.

» The right to request restrictions of certain uses and disclosures of my protected health. However, I understand that IMAGECARE does not have to agree to honor my requested restrictions.

» The right to receive confidential communications of protected health information

» The limited right to inspect and copy certain protected health information.

» The right to request to amend protected health information.

» The right to request an accounting of disclosures of protected health information.

» The right to obtain a paper copy of the Notice of Privacy Practices from IMAGECARE upon request.

*I also understand the IMAGECARE reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.*

Signature: Date:

Relationship to Patient *(if signed by a personal representative of patient)*

IF you would like to authorize a person or persons to be able to talk about your treatment or account, please sign below.

My treatment and account status may be discussed with ______________________
(Name)

Relationship: Date:

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imagecare DENTAL

## We're Committed to Handling the Financial End with You in Mind!

In order to maintain an ongoing, positive relationship with our patients, we would like to disclose our options for financing procedures for your dental health.

Payment in full is required at the time services are rendered.

If you have an ***insurance*** plan that our office can accept, we will be glad, as a courtesy, to file to the insurance company for your benefits. We will estimate your copay based on information we obtain from your insurance company. This co pay is expected at the time services are rendered. If the insurance company pays less than expected or not at all, we will be glad to bill you for the balance. This payment is expected in full upon receipt.

Please make sure we have your most current insurance information on file. Refiling of claims will be subject to a $25 refile fee.

If you would like to take advantage of ***CareCredit***, we can help you in your application. This service allows you to pay out your dental health services over a period of up to 12 months, depending on the cost of your treatment.

***For the comfort and convenience of our patients, we ask for payment to be made on the day of appointment prior to being seated for treatment in the operatory. This allows our patients to take care of financial arrangements while not under the influence of anesthesia or sedation. After a dental procedure, it is comforting to know that you will be able to leave immediately after your visit without standing in the business area waiting on our financial staff.***

We accept Visa, American Express, MasterCard and Discover. We also welcome your personal checks with proper identification.

We thank you for your cooperation in our financial policy. We are dedicated to your oral health and will help you in any way we can.

I have read and understand Imagecare Dental's financial policy.

Signature: Date:

**SUBMIT**

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