DENTIST 4 UNINSURED
657 West Avenue J
Lancaster, CA 93534
Phone: 661-726-1010
Fax: 661-948-2613

Written Financial Policy

Thank you for choosing Dentist 4 Uninsured. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible for our patients by offering several payment options.

Payment options:
You can choose from:

- Cash, Visa, Mastercard, American Express, or Discover Card
- NO interest* Payment Plans** from Wells Fargo or Lending Club
    - Allow you to pay over time with no interest*
    - Convenient, low monthly payment plans** also available
    - No annual fees or pre-payment penalties

Please note:
Dentist 4 Uninsured requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment***

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

_____
Patient Name (please print)

_____ _____
Patient, Parent or Guardian Signature Date

*If treatment cost is $499.00 or above. Otherwise, interest assessed from purchase date. Minimum monthly payments required.
**Subject to credit approval.
***However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

HIPPA Privacy Rule Individual Consent and Acknowledgement Agreement

Dentist 4 Uninsured

I acknowledge and accept the patient contact procedures of Dentist 4 Uninsured/Dental Group that:

- I will respect the requirements that Dentist 4 Uninsured/Dental Group must meet in accordance with the HIPPA Privacy Rule;
- I will be contacted by Dentist 4 Uninsured/Dental Group 24 hours before my appointment;
- I can be contacted on the telephone numbers listed on the Dentist 4 Uninsured/Dental Group Information Sheet and you **[ ] may or [ ] may not** leave messages for me;
- If I cannot be contacted personally, I authorize you to discuss my dental condition with the following people:

Name	Relationship	Contact #	Date	Cancelled Date

Signature of Individual or Legal Representative _____

Printed Name of Individual or Legal Representative _____ Date

_____

DENTIST 4 UNINSURED
657 West Avenue J
Lancaster, CA 93534
Phone: 661-726-1010
Fax: 661-948-2613

HIPPA Privacy Rule Individual Authorization Agreement

Authorization for the disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations [§164.508(a)]

I, _____ understand that as part of my health care, Dentist 4 Uninsured/Dental Group originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who may contribute to my health care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify the services billed were actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that Dentist 4 Uninsured/Dental Group's *Notice of Privacy Practices* provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Dentist 4 Uninsured's Notice of Privacy Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me. **PHI Authorized:**

Purpose Authorized:

Parties to whom my PHI is authorized to be released: I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that Dentist 4 Uninsured /Dental Group has already taken action reliance thereon.

[ ] Accepted [ ] Denied

Signature of Individual or Legal Representative _____

Printed Name of Individual or Legal Representative _____

Date _____

DENTIST 4 UNINSURED
657 West Avenue J
Lancaster, CA 93534
Phone: 661-726-1010
Fax: 661-948-2613

HIPPA Privacy Rule Individual Consent Acknowledgement Agreement

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS [§164.506 (a)]

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES NOTICES [§164.520 (a)]

I, _____ acknowledge that I have been provided with and understand Dentist 4 Uninsured /Dental Group's Notice of Privacy Practices describing the uses and disclosures of my protected health information. I understand that it is part of my health care, Dentist 4 Uninsured /Dental Group originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who may contribute to any healthcare.
- A source of information for applying my diagnosis and dental information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I request the following restrictions to the use and disclosure of my health information

"Insert any additional patient specific requirements to be included"

I understand that:

- I have reviewed Dentist 4 Uninsured/Dental Group's Notice of Privacy Practices prior in signing this consent
- That Dentist 4 Uninsured/Dental Group reserves the right to change his notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Dentist 4 Uninsured/Dental Group is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Dentist 4 Uninsured/Dental Group has already taken action in reliance thereon.