Consent for Dental Treatment

I, the undersigned, authorize Kirlough Family Dentistry (and its' agents) to take x-rays, study models, photographs and any other diagnostic aids that are deemed appropriate to make a thorough diagnosis of my dental needs.

I authorize Kirlough Family Dentistry (and its' agents) to perform any and all necessary forms of treatment, medication, and therapy that may be indicated. I authorize and consent that Kirlough Family Dentistry employ any such assistance as is deemed necessary.

I further authorize the release of any information, including the diagnosis, x-rays, and records of any examinations or treatments rendered to my insurance company (where applicable), consulting professionals or others who may request my records.

Signature (Authorized Representative) _____

Printed Name (If signed on behalf of patient) _____

Date _____

Kirlough Family Dentistry

We, at Kirlough Family Dentistry, thank you for choosing us as your dental health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have questions or concerns regarding our fees, policies or responsibilities, please feel free to contact us at any time.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service, unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting cash, money orders, Visa, MasterCard, Discover, American Express, and in-state checks. We also offer third party financing through CareCredit. With regards to payment arrangements, please speak to our staff in person.

A 35.00 service fee will be charged for all returned checks.

Interest

Interest will incur at a rate of 5% if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and do all that we can to help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

- **When insurance is involved, we are contractually obligated to collect all copayments, coinsurance, and deductibles, as outlined by your insurance carrier, at the time of your appointment.**
- It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur.
- Even a preauthorization of service does not guarantee payment from your insurance carrier.
- We also require photo identification when accepting insurance information.
- It is a patients' responsibility to know if our office is participating or nonparticipating with their insurance plan.

Kirlough Family Dentistry

- Failure to provide all required information may necessitate payment for all charges by the patient.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with regards to your claim. You are responsible for all out-of-network fees. If were are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Missed Appointments ____

We require notice of cancellations 24 hours in advance during office hours (not messages left on voicemail). This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee will apply. These fees are typically $35.00. We reserve the right to dismiss a patient from the practice for repeated missed appointments without notification.

Medical Records Fees ____

Under federal law, patients are entitled to have access to their protected health information and we will respect all these guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records at a reasonable cost-based fee for copies including the copying, supplies, labor, and postage.

Financial Hardship ____

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our office.

Timeliness of Appointments ____

We try to see everyone in a timely manner. Emergencies and other unexpected difficulties sometimes arise from time to time that cause us to fall behind our schedule for the day. If we are taking too long, please let our staff know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Kirlough Family Dentistry whenever applicable. I agree that I am responsible for all amounts owed for services rendered by Kirlough Family Dentistry.

_____ _____

Signature of Insured/Non-Insured or Authorized Representative Date

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer