UNION CITY DENTAL ASSOCIATES

NEW PATIENT REGISTRATION

First Name: _____ Last Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Ok to receive email correspondence? (Appt reminders, etc.): YES / NO

Social Security: _____ D.O.B: _____

Sex: Male / Female

Marital Status: Single / Married / Divorced / Separated / Widowed / Partnered

Emergency Contact: _____ Phone: _____

UNION CITY DENTAL ASSOCIATES

Consent for Services:

Thank you for choosing Union City Dental Associates. In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with your dental insurance, we call your insurance company and verify your benefits. The information we receive from your insurance company is **only an estimation** of coverage and **not a guarantee**.

After you have been seen in our office, we will file your claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.

For all patients without insurance, payment is due at the time of service.

Treatment prices are guaranteed for one year. After one year, prices may change due to increasing product costs and business expenses.

After your initial comprehensive exam in our office, new exams are needed every 6 months to ensure that the condition of your mouth remains the same. All dental emergencies require a new exam and x-rays to diagnose your condition and provide proper treatment regardless of the date of your last exam. For patients without dental insurance, a payment is requirement for each exam. For patients with dental insurance, your insurance may or may not cover the cost of additional exams, we will verify your benefits prior to being seen.

There is a $25 cancellation fee for all appointments cancelled within 24 hours of your appointment time. This cannot be billed to insurance and must be paid prior to being seen for your next appointment.

I have read and understand the billing process at Union City Dental Associates.

_____
Patient's Name (Printed)

_____
Patient Signature

_____
Date

UNION CITY DENTAL ASSOCIATES

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. For example, teeth cleaning.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, sending your bill for your visit to your insurance company for payment.

Healthcare Operations: include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with a member of our staff.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Signature:_____ Print Name: _____ Date:_____