Worcester Sleep Dentistry

Consent for Treatment

A. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
B. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
C. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.
D. I authorize CNE Dental to deduct any outstanding balance on my account on my credit card a and/or any cancelation fees.

Patient's signature: _____ **Date:** ___/___/___

Parent/Responsible party's signature: _____ **Date:** ___/___/___

Financial Policy Agreement and Cancellation Policy

The goal of CNE Dental is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We want to make certain that our financial policies are clear and understood by you. If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount **up to** 60 days. We will file the appropriate claim forms with your insurance company that you provide us with your personal information including social security number and date of birth. We will also assist you in understanding your dental plan benefits. If your insurance denies coverage, or if we do not receive payment within 60 days from the date services rendered, that amount will then become due and payable by you. Please remember that your coverage is a contract between you, your insurer and/or your employer. Although we will make every effort to help you obtain your benefits, we cannot guarantee your insurance will pay.

Your payment is due at time of service

Fees for treatment are due at the time treatment is rendered after the deduction of your insurance benefit estimate as described above. Payment options: Cash, Check, Debit Card, Credit Card (Visa, Master Card, Discover Card) and Care Credit.

Patient Responsibility

I acknowledge my responsibility for payment of services rendered by CNE Dental in accordance with CNE Dental fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on your account is not paid within 30 days of statement, your account will become delinquent and will be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges.

Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with CNE Dental.

Records/ X-Rays

CNE Dental understands that you have the right to request copies of you dental records/x-rays. *We can provide your notes and x-rays with a fee of $50.00.* We are licensed by the Massachusetts Board of Radiology to take X-rays, and are required by law to keep all original copies of your dental records.

Initials _____

Cancellation Policy

Here at CNE Dental of we understand that interruptions to our schedules can and will occur. We are aware that from time to time most people will encounter some unfortunate circumstances beyond their control. However, our time is scheduled in order to focus upon your oral health concerns. The team at CNE Dental makes every effort to make your time at our office pleasant and productive. We take pride in the fact that our appointments are efficient and that you are not subject to lengthy waits in our reception area. All appointments when made have a specific date, time of day, and length of stay, so that you are better able to maximize your time here. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice. We are committed to seeing our patients on time and respecting their time. Late cancellations (less than 48 hours notice) failed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule we request 48 hours notice for cancellations or rescheduling of appointments. In the instance of a late cancellation (less than 48 hours notice) or a failed appointment there will be an **$80.00** charge per **hour** of scheduled appointment and patient will be added to our waiting list.

Acknowledgement of Receipt of Statement of Privacy Practices/Cancellation Policy and Financial Policy

I acknowledge that I have received a copy of the Statement of Privacy Practices and Cancellation policy for the office of CNE Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. CNE Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to CNE Dental. We may decline treatment if you revoke this consent.

Name of Patient: _____ Date ___/___/_____

Signature of Patient: _____ Date ___/___/_____

Health Insurance Portability and Accountability ACT

The HIPAA Privacy Rule creates national standards to protect individual's medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patient's privacy rights.
- And it strikes a balance when public responsibility supports disclosure of some forms of data-for example, to protect public health.
- For patients-it means being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.
- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections
- It empowers individuals to control certain uses and disclosures of their health information.
- Acknowledgement of receipt of Notice of Privacy Practice You may refuse to sign this acknowledgment

I, _____, have access to and read a copy of CNE Dental Notice of Privacy Practice, and understand my right pertaining to my personal healthcare and insurance information.

_____ _____/_____/_____

Patient's Signature Date

_____ _____/_____/_____

Witness Signature Date