8663 W. Union Hills Dr. #400, Peoria, AZ 85382 Phone: 623-933-850 Fax: 623-933-8501
www.victornitudds.com

Notice of Privacy Practices

Statement on HIPPA: Health Insurance Portability And Accountability Act

The U.S. Congress mandated the **Health Insurance Portability and Accountability Act in 1996**. The Law became effective April 14, 2003. It is designed to protect the confidentiality of patient medical information that has been shared in the past between health insurance plans, banking establishments, and employers. It is the intention of **Victor Cosmetic and Family Dentistry LLC** to respect the privacy of our patients and to abide by the letter and spirit of the law to our utmost ability.

Our policy is that we will not release personal information to any outside source except for dental insurance compensation forms which are requested by our patients to be filed for them, or to a referred specialist or other medical practitioner as required for treatment. If information is requested outside of the normal information requested by insurance companies for processing of claims we require your written permission to release such information. At the present time this office is doing electronic filing of claim forms (internet or fax).

Information submitted to dental insurance companies for payment, and to other medical practitioners as necessary for treatment, falls under the **HIPPA** Act. Therefore, to be in compliance with the **HIPPA** Act we must obtain signed consent forms from all our patients to release this information. The added extra minutes that will be needed to fill out this form will serve to protect you and your medical records.

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Financial Policy

Our office files primary insurance as a courtesy for all of our patients. **Please bring your insurance card with you and keep our office informed of all insurance changes and special authorization requests.** Payment is expected at the time of service by cash, check, VISA, MC, American Express or Discover. Patients are responsible for the appropriate deductible and co-insurance. For members of dental plans in which we participate, the appropriate deductible, co-pay, or patient's portion will be collected. ***Your insurance is a contract between you and your insurance company. You are responsible for all bills regardless of the type of insurance coverage you may have.*** Please contact your insurance company to verify coverage for our services. We allow 60 days for your insurance carrier to pay. After that time the unpaid balance is due to payable by the patient.

You are expected to pay all charges in full at the time of service if:

1. You have no insurance coverage.
2. You prefer to file your own insurance.
3. Your insurance carrier sends payment directly to you.
4. Our office cannot verify insurance benefits.
5. Proper authorization has not been received.

DELINQUENT ACCOUNTS

1. Accounts past due will be placed on COD status at which time all charges must be paid in full at each visit until account is brought current.
2. Accounts past due are subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office.

RETURNED CHECKS

There is a $25.00 service fee on all returned checks. Returned checks must be redeemed with certified funds (cashier's check, money order or cash).

MINOR PATIENTS

We require that a minor patient to be accompanied by an adult (parent or legal guardian). The adult accompanying the minor patient is required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY THE TERMS OF THIS POLICY.

______________________________________ ___________________

SIGNATURE (Responsible Party) DATE

48-HOUR NOTICE TO CANCEL APPT. OR A $100 NO SHOW FEE _____***INITIALS***

Please understand that our intent is to inform before we perform. A well-informed patient is a happy patient. We pride ourselves on maintaining a harmonious professional relationship with our patients.

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Acknowledgement of receipt of notice of privacy practices and consent for use and disclosure of health information.

I, ____________________________________ have received and read a copy of Victor Cosmetic and Family LLC **Notice of Privacy Practices**.

I understand that this office will only release information that is pertinent to the processing of my insurance claims when applicable. Otherwise, there will be no release of any information unless to a referring specialist or other medical professional as required in order to facilitate treatment.

I am aware that electronic filing to insurance companies may now or in the future be done for me by Victor Cosmetic and Family Dentistry LLC.

I am aware that I have the right to review my heath records upon reasonable notice, and to request correction or amendment of any inaccurate information contained therein.

I am in consent with this office and their practices of safeguarding my private health information according to HIPPA rules and guidelines and that this office will notify me of any further changes or requests.

____

Name (please print)

____

Signature Date

If this consent is signed by a personal representative on behalf of patient please complete the following:

Personal Representative's
Name____

Relationship to
Patient:____