AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION HIPAA ACKNOWLEDGEMENT

I authorize Happy Smiles Dental office to release health information identifying me under the following terms and conditions:

1. Detailed descriptions of the information to be released: Insurance information, related X-Rays, treatment recommendation(s), and necessary related information.
2. To whom may the information be released, including but not limited to: Referring doctors, insurance carriers, laboratories.
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).
4. Expiration date or event relating to the individual or purpose for the release.

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if choose not to sign this authorization. In that case, you may personally be responsible for all of your fees incurred at our practice. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is that if we have already acted in reliance upon the authorization. If you want to revoke your authorization, you must provide us a signed written note stating that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient has a legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this possibility.

If you would like a copy of your records like your X-Ray images for yourself or to be transferred to another office or health care facility, you **MUST provide a written request and sign Release of Information Authorization Form**. After we receive the signed request, we will prepare you with copies of records requested within 21 business days from the time of request. **There may be a charge of $30 for this service.** The records will be then available for you to pick up by yourself or a specified designated person (who can come on your behalf with proof of Identity) or mailed to your address or requested entity using U.S. Postal Service First Class Mail, or email if you request so.

We will receive direct or indirect remuneration from a third party, such as your insurance carrier, for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Guardian Signature: ______________________________________ Date: ___________

Name of Patient/Guardian (Please Print): ____

NO SHOW, MISSED APPOINTMENT OFFICE POLICY

To give you the best care possible, when our office books your appointment, we are setting aside a dedicated chair, time, and resources just for you. We only ask that if you must reschedule your appointment, that you please provide us with **at least 2 business days' notice (Please note we are Open Tuesday through Saturday)**. This courtesy makes it possible to give your reserved time slot to another patient who could benefit from the appointment.

There is a charge of $50 per hour for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future scheduled appointment privileges.

Patient/Guardian Signature: ______________________________________ Date: ___________

Name of Patient/Guardian (Please Print): ____

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE POLICY

We are committed to providing you with the best possible dental care. Payment for services are due at the time of service provided. We accept cash, checks, major credit cards and third-party financing such as Care Credit. We urge patients to meet with our Financial Coordinator to discuss financial arrangements prior to treatment to avoid any misunderstandings. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance. We will gladly discuss your proposed treatment(s) and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and are usually covered close to the maximum allowance determined by each carrier. You are responsible for any balance not covered by your insurance company.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are also responsible for any deductibles not met, any amounts over your yearly contract allowance, and any co-payment amounts.

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges for services rendered are your responsibility.

I understand that regardless of my insurance, I am responsible for the balance on my account for the professional services rendered. I also agree that if I do not pay my account balance with 30 days, I will be responsible for any interest due (1.5% per month) and/or any court costs and attorney fees to the full extent of law.

I also agree to allow Happy Smiles Dental to submit information on my behalf to my insurance carrier. I also authorize my insurance carrier to pay the benefits directly to Dr. Hamidzadeh and/or Happy Smiles Dental LLC and it's associates.

I have read and understand this form in full.

Name of Patient/Guardian (Please Print): ____

Signature: ____ Date:________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ have read a copy of this office's Notice of Privacy Practices.

Name of Patient/Guardian (Please Print): ____

Signature: ____ Date:________________