ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

And

Patient consent form for the offices of:

Justin Patay, D.M.D. FAGD

Roland L. Postlewait, D.D.S.

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the health insurance portability and accountability act of 1996 HIPAA. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
Obtaining payment from third-party payers (e.g. my insurance company, collection agencies)
The day-to-day health care operations of your practice including appointment confirmation calls to my home, cellular phone, or place of employment.

I have also been informed of, and given the right to review and secure a copy of *your notice of privacy practices,* which contains a more complete description of the uses and disclosures of my protect health information, and my rights under HIPAA, I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and is disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed this day _____ of _____ ,20 ___ .

Print patient name _____

Relationship to patient _____

*Please list those parties we can release information to other than those listed above (I.e. spouse, caretaker, partner, etc.)

Signature: _____ _____

For office use only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because: _____

_ Individual refused to sign

_ Communication barriers prohibited obtaining the acknowledgment

_ An emergency situation prevented us from obtaining acknowledgment

__ Other (please specify) _____

FINANCIAL INFORMATION

I understand that I, as the patient, and fully responsible for payment on my account with Dr. Patay regardless of any insurance coverage. All professional services rendered or charged to the patient and estimated patient portions will be collected at the beginning of any restorative procedures. Necessary forms will be completed to help expedite insurance carrier payments. It is also my responsibility to inform the office of any billing or insurance changes. I understand that the collection agency currently being used charges 40% of the unpaid balance and that this amount will be passed on to me if and/or when my account is sent to collections. Also, I understand that, a charge of $25 will be assessed for any unpaid or otherwise dishonored check returned by my bank. ____(initial)

RELEASE OF INFORMATION

I authorize the release of any information regarding the course of my examination and treatment to the insurance company's listed, and/ or any dentist I may see. I've further authorized Dr. Patay's staff to obtain medical information from any source deemed necessary for my treatment. A copy of this authorization shall be considered as effective and valid as the original.

___ (initial)

ASSIGNMENT OF BENEFITS

I authorize and assign any payment directly to Dr. Patay. I further authorize to them any surgical and/or dental benefits otherwise payable to me for services. My consent is granted to use this original or copy of effective valid as the original.

___ (initial)

I understand dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurances has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that this is only an estimate and is subject to modification depending on unforeseen or undiagnostic circumstances that may arise during the course of treatment.

___ (initial)

CANCELLATION AND/OR RESCHEDULING

I understand that I am required to give at least 48 hours' notice to cancel or reschedule an appointment. I understand that if I fail to give 48 hours' notice, my account will be charged a fee of $46 per hour for each scheduled hygiene appointment and a fee of $88 per hour for each scheduled hour with the doctor.

___ (initial)

EXAMS AND X-RAYS

Our office upholds the ADA and NAC codes: 631.210 (NRS 631.190,631.310,631.313,631.317). These codes state that a dental examination must be completed not more than 18 months before the services are to be performed. The dentist has a professional obligation to provide treatment that they feel is in the best interest of the patient. The majority of dental offices in this state require x-rays be taken along with the exam or prior to treatment. This policy ensures that a thorough diagnosis is obtained. Our office policy is bite wings every 12-18 months and a full mouth series or Panoramic x-ray every 5 years.

___ (initial)

OFFICE STATEMENT

Our office makes every effort to efficiently schedule appointments, calculate an estimate of the patient's portions not covered by insurance and accommodate the very needs of our patients. Should conflict arise, please contact our office. We will promptly and professionally address your concerns and work towards a resolution. Our office does maintain a **no tolerance policy** for abusive language and/or behavior. If offensive language/ behavior should occur, we reserve the right to discontinue treatment and withdrawal from being your primary dental care provider. If you disagree with the office policies above you have the right to seek treatment elsewhere. Your records will then be transferred to another dental office of your choice

I have read the above, financial agreement, release of information, assignment of benefits, cancellation and/or rescheduling and office statement, and agreeing to the terms mentioned, do hereby sign my name.

X _____ **X** _____

Patient Signature Date

PARENTAL CONSENT TO TREAT MINOR CHILD

I, _____, give my consent to Dr. Patay to evaluate and treat my minor child.

X _____ **X** _____

Patient Signature Date