Acknowledgment of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that all health Care providers give patients a copy of the Notice of Privacy Practices and make a good Faith effort to obtain an acknowledgement of receipt of same.

By signing this form I confirm that I have received a copy of the Notice of Privacy Practices.

PRINT NAME:_____

SIGN NAME: _____

DATE: _____

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Dental specialists when I (patient) require additional treatment, My (patient's) insurance company for billing purposes

Patient Health Information authorized to be disclosed:

Vital Statistics, Medical History, Dental History, Progress notes, Treatment plan, Radiographs, Models

For the specific purpose of:

Providing comprehensive dental care, claim payment

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of PHI being used or disclosed under federal law.
4. Refuse to sign this authorization
5. Receive a copy of this authorization
6. Restrict what is disclosed with this authorization

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected PHI.

Patient or Pt rep Date

CROSS KEYS
DENTAL

GENERAL CONSENT FOR TREATMENT

Dr. Kurudi/ Dr Budda will examine the patient for a Full Mouth Exam or specific Chief Complaint, provide a diagnosis and explain this diagnosis, treatment options, risks and benefits of various treatments to the best of her ability.

He/She will refer you to a specialist for procedures that require more in depth treatment- Common examples -

1. Difficult extractions, Wisdom teeth extractions, procedures requiring an Oral surgeon
2. Molar root canals requiring an Endodontist
3. Crown Lengthening procedure requiring a Periodontist
4. Uncooperative child requiring a Pedodontist

All dental and anesthetic procedures have associated risks. These may be but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment by an Oral Surgeon
- Involvement of nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue or other areas
- Bruising, swelling, sensitivity or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside the tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I give General Consent for Dental treatment to Dr. Kurudi/Dr Budda Cross Keys Dental LLC.

Patient Signature_____ Date_____

Financial Policies

No Show Policy

While Cross Keys Dental will attempt to remind you of scheduled appointments, it is the responsibility of the patient to keep track of scheduled appointments. The office may require that the patient provide a credit card to reserve appointments. Obviously, there may be extenuating circumstances that prevent the patient from providing sufficient cancellation notice. In these cases, the office may request evidence of extenuating circumstance.

Bounced Check Policy

Any payment made to our practice with check that is bounced will be subject to a $30.00 bounced check fee. In addition, any and all legal or debt collection fees will be the responsibility of the patient.

Crowns, Bridges and Denture Work

Crowns Bridges and Denture word will typically require multiple visits to the office. It is crucial that the patient complete all visits until the prosthesis is fitted, within a few weeks to get the best fit. As a courtesy, the office will try to schedule the insertion appointment with the patient, when they are in the office, however any uncollected prosthesis will be charged to the patient regardless of whether the patient completes the fitting appointment.

Minimum Credit Card Transaction

Credit Card transaction at the office must exceed $20.00

X-Ray Copies

Copies of X-rays requested by the patient will be charged at $25.00 per copy. This fee will not be paid by the Insurance Company.

X_____

Patient Signature **Date**

Authorization for Payment of Dental Services (Signature on File)

I hereby authorize and direct payment of the dental benefits payable to me, directly to Cross Keys Dental, LLC/DBA

X_____

Subscriber Signature Date

Balances not paid by insurance because it is the patient's co-insurance or because the procedure is not a covered benefit, changes to insurance coverage, or for any other reason will be the sole responsibility of the patient. The patient will be billed for any outstanding amount as soon as the "Explanation of Benefits" is received from the insurance company.

X_____

Subscriber Signature Date

Any unpaid balance must be paid in full before any new service can be provided. Any outstanding balance will accrue interest at the rate of 1.5% per month and if account becomes delinquent past three months, any and all legal and or collection fees will be added to an outstanding balance.

X_____

Subscriber Signature Date