Ukiah FAMILY DENTISTRY

Matthew Jeffers D.D.S. Kevin Jeffers D.D.S.

Office Procedures

1. I authorize the following person(s), which means the doctor and staff may speak freely to the named personal representative regarding all my protected health, medical, dental, treatment and billing information.

   Name ______________________ **Relationship** ______________________

2. **For my child(ren)**, I authorize the following named person(s) to authorize dental treatment for my named children. The Doctor and staff may speak freely regarding my child(ren) protected health, medical, dental, treatment and billing information.

   Name of Authorized Person/Relationship ______________________ ______________________

   List of Minor Children ______________________ ______________________

3. I authorize Ukiah Family Dentistry to examine and provide dental treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Ukiah Family Dentistry. I authorize Ukiah Family Dentistry to release any dental/medical or incidental information that may be necessary for either medical/dental care or in the processing of applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which, specialists and providers are assigned to me according to my insurance policy rule and that **KM Jeffers Dental Corporation, dba Ukiah Family Dentistry, is not contracted with any insurance company**. It is Ukiah Family Dentistry's procedure to share Protected Health Information with labs and consulting physicians, dentists, insurance companies, trust funds and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.
4. ______ (initial) **I understand that payment is due at the time of service, unless other arrangements have been made.**
5. I authorize Ukiah Family Dentistry or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment, which is mutually agreed upon by me. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
6. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information. However, our office was designed before the HIPAA Law so please be respectful of other patients' privacy.
7. I have received the Dental Materials Fact Sheet dated May 2004.
8. It is our office procedure that we mail reminder postcards asking you to call to schedule an appointment and we also leave messages or text reminding you of your appointment(s).
9. ______ (initial) The Limited Warranty is available upon request. Failure to have your recommended clinical hygiene appointments and exams voids the limited warranty.
10. ______ (initial) A broken appointment is a loss to everyone. Please give **48 business hours'** notice if you are unable to keep your appointment. You may be charged for a missed appointment.

Signature of Patient/Guardian: ______________________ **Date:** ______________________

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I understand that as part of my health care, Ukiah Family Dentistry originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Ukiah Family Dentistry **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

* I have the right to review Ukiah Family Dentistry Notice of Privacy Practices prior to signing this acknowledgement;
  that Ukiah Family Dentistry reserves the right to change their Notice of Privacy Practices and prior to implementation of this, will mail a copy of any revised notice to the address I've provided if requested.

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, Ukiah Family Dentistry, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

* a basis for planning my care and treatment;
* a means of communication among the health professionals who may contribute to my health care;
* a source of information for applying my diagnosis and surgical information to my bill;
* a means by which a third-party payer can verify that services billed were actually provided;
* a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

* I have the right to object to the use of my health information for directory purposes;
* I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Ukiah Family Dentistry, is not required by law to agree to the restrictions requested.
* I may revoke this consent in writing at any time, except to the extent that Ukiah Family Dentistry, has already taken action in reliance thereon.
* By law, we are unable to submit claims to payers under assignment of benefits without your signature. You will however be able to restrict disclosers to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign.

I agree to all of the above Office Procedures of **Ukiah Family Dentistry**, and give my authorization to all of the above procedures.

Signature of Patient/Guardian: ________________________________**Date:**__________________