Dental Office Rules & Policies

1. All patients who are over 18 years of age must show their picture ID.
2. If applicable, co-payments must be paid at time of visit.
3. All patients must show their current Dental Insurance Card.
4. Patients must have their current health information with all prescribed medications.
5. We accept cash, check, VISA, MasterCard, and Discover. Payment of your “estimated” portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. We will contact your insurance in order to provide an “estimate” of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefit nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance.
6. All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit the payment. If there is still no payment after this time, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office receive payment from your insurance after it has been paid by you, a prompt refund will be issued.

For All Appointments
1. It is your responsibility to remember your appointment time. However, we will remind you with a courtesy call.
2. If you must cancel, you must call at least 24 hours before your appointed time. Otherwise, a broken appointment note will be added to your record.
3. If you change your phone number, please call and provide our office with the new number.
4. Any broken appointment on a Saturday will result in not being able to see you for three-months on a Saturday.
5. There is a $30 charge for all returned checks.
6. If you are going to be more than 10 minutes late, then please call and let us know.

Children
1. Children under 18 will not be seen unless accompanied by a parent/guardian.

I have read and understood the clinic’s rules and policies and do hereby agree to all the above.

Signature:__________________________________________ Date:______________
HIPAA PATIENT CONSENT FORM

Notification:
As you may be aware, a new federal law went into effect on April 14, 2003. The Health Insurance Portability and Accountability Act (HIPAA) require Dr. Kamran Hameed, DMD, PA to provide you with its Notice of Privacy Practices. It outlines your privacy rights as a patient.

We may use information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family:
Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. Health Professionals may discuss Protected Health Information (PHI) with parents of minor (under age of 18 or in school and covered by parent's insurance policy) unless specifically instructed not to do so.

Worker's Compensation or Disability Insurance:
We may disclose health information to extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

For the patient's review and signature:
I understand that, under the Health Insurance Portability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
  * Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
  * Obtain payment from third-party payers.
  * Conduct normal healthcare operations, such as quality assessments and the physician's certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time or come to our office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment on health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have action relying on this consent.

Patient Name (please print):_________________________________________________________

Signature:________________________________________________________________________

Relationship to Patient:_____________________________________________________________