Brazos Valley Endodontic Associates
Steven D. Calkins, DDS, PA • Sally R. Hays, DDS, MS
2901 E. 29th Street, Suite 117 • Bryan, TX 77802 • (979) 776-6152

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability 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 healthcare 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 physician certifications.
- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).
- We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 to obtain a current copy of the *Notice of Private Practices.*

Patient Name: _____Date: _____

Signature:_____ Relationship to Patient: _____

List of people authorized to have access to your protected health information:

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: • Individual refused to sign • Communications barriers prohibited obtaining the acknowledgments
- An emergency situation prevented us from obtaining acknowledgements
- Other (Please Specify):

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DENTAL INSURANCE AND OFFICE POLICY AGREEMENT

Thank you for choosing us as your dental care provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policies.

If you are covered by a dental insurance plan, this office will complete and submit your forms for the treatment rendered. Please remember your insurance policy is a contract between you and your insurance company. Our office policy is to collect 50% on the day treatment is initiated. As a courtesy to you, our office will file an insurance claim on your behalf. Please be aware that the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. If our office receives payment from the insurance carrier, you will either be billed for any remaining balance or refunded any over-payment. Should you default on your account, you agree to pay any and all fees associated with collecting the debt, in addition to the full amount on your account.

If there is a delay of ninety (90) days or more by the insurance company in paying your claim, then it will be your responsibility to promptly pay the outstanding balance in full. Should your insurance carrier deny the claim, it will be your responsibility to file a dispute at your discretion.

If you have any questions regarding your insurance policy, we recommend you contact your insurance company regarding the specifics and details of your plan. The type of treatment you need and receive from this office is based on Dr. Calkins or Dr. Hays' diagnosis and professional judgement, independent of insurance coverage.

Insurance Company Name _____

Ins. Co. Address _____

Ins. Co. Phone _____ Group # _____

Employer Name _____

Subscriber/Policy Holder _____ Subscriber DOB_____

Subscriber ID/SS#_____ Patient relationship to Subscriber _____

I understand that I am responsible for any and all charges not covered by my insurance company. Brazos Valley Endodontic Associates is not affiliated or "in-network" with any insurance company.

Patient/Responsible Party _____ Date _____