Mark Riechman, DDS, PC.
and Associates
General and Cosmetic Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name:_____

Address:_____

Telephone:_____E-mail_____

Patient #:_____SSN:_____

Section B: To the Patient-Please Read the Following Statement Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent, Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as describe in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and Your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and Disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

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Financial Policy

We believe that our office provides the highest quality care at very affordable and reasonable fees. We also believe in trying very hard to be fair in collecting those fees and to avoid problems with our patients' accounts. From time to time, however, misunderstandings and problems to arise.

In an attempt to avoid these misunderstandings, we offer to you this detailed summary of our Financial Policy:

1. We expect everyone to pay for their portion of the services performed at the time they are performed unless other arrangements have been made in writing, in advance.

2. We accept cash, checks, Visa, MasterCard, Discover and Care Credit (see #6).

3. As a courtesy, we will prepare and submit your insurance forms to your primary carrier and will monitor payment of your claim for up to 60 days after submission. ***After 60 days you will be directly responsible for the payment of any charges that have not be considered or paid by your insurance company.*** If you have secondary insurance, we will be happy to assist you in submitting the claim.

4. ***We will not be responsible for handling your claim after 60 days and will not negotiate for payment from your carrier.*** Be advised that insurance coverage varies and not all services may be covered. For example, policy terms such as "Reasonable & Customary" and "Prevailing" are sometimes used to limit benefit coverage. ***If any of our charges are not paid by insurance, you will be directly responsible for those unpaid charges as specified in #3.*** If you have any questions concerning your claim or your coverage, you must contact your carrier and/or your employer directly. See our flyer entitled "What you should know about Dental Insurance".

5. Balances over 90 days will incur a 1.5% finance charge. To avoid these charges, simply pay your balance within 90 days of services rendered.

6. Care Credit is a dental finance company which offers, at no cost to you, 3, 6, 12 and 18 month payment plans with no interest for balances in the amount of $300 or greater. We have contracted with Care Credit for this purpose. It is a very attractive plan and we have found it works extremely well.

7. Unpaid balances over 90 days with no prior arrangement with us for payment will be sent to a collection agency.

8. We will charge a $25.00 fee for all NSF & returned checks. Any remaining balance on the account must then be immediately paid in full in cash.

Dr. Mark Riechman, D.D.S., P.C.

Patient Signature: _____ Date: _____