Patient Name: DOB:

Notice of Privacy Practices & HIPAA Consent

Patient Privacy is important to our practice. We are required by law to maintain privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

This HIPAA Consent/Sharing was signed by (Signature) *Today's Date*

_____

Relationship to Patient (if other than patient)

(see other side)

Patient Name: DOB:

Financial Consent & Office Guidelines

Financial Obligation & Payment Guidelines

All patients: I understand that any responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered regardless of whether I have medical or dental insurance. I am responsible for all fees for services rendered. I am responsible for all fees necessary to collect my account. Any quoted fees will be honored for a period of 3 months. I am aware that any balance carried past 90 days will be subject to interest at 7%, simple interest, and to a 5% rebilling fee at each statement period thereafter, as well as being sent to collections.

Patients with medical or dental benefits: I authorize McMahon Family Dental and their staff to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to them, and to handle any necessary claim appeal(s) on my behalf. I understand that insurance billing is a courtesy to me by McMahon Family Dental, and that I have ultimate responsibility for insurance claims, billing and payment of all charges regardless of insurance payment or reimbursement. **I understand that it is MY RESPONSIBILITY to know my specific plan/policy coverage.** If a pre-treatment estimate has been sent to my insurance company, at my request, that this is not a guarantee of payment. I understand that the estimate is based on best available information, but the final charge for which I am responsible will be based on actual treatment. My dental benefits may cover more or less than is estimated, if any. McMahon Family Dental has the capability to estimate my out-of-pocket cost of treatment based on an estimate of payment from my benefits. **Therefore, I understand that payment is expected in full at the time services are rendered, based on this estimate and that the final charge for which I am responsible may change based on treatment and on insurance payment (if any).**

Patients without dental benefits: I understand I am required to pay in full at the time services are rendered.

Patients with a Quality Dental Plan (QDP) Membership: I understand that this membership plan is offered in-office only and CANNOT be used in combination with any insurance benefits. I understand that I am required to pay in full at the time of service.

Any reference in this Patient Information packet or in any literature you receive from us to "we", "us", "our", "the Practice," "McMahon Family Dental," or similar language is considered to be a reference to John F. McMahon DDS, PLC.

All balances must be paid in full within 90 days to avoid being sent to collections.

Payment Plan Options

McMahon Family Dental accepts cash, checks, and all major credit cards as forms of payment. Payment plans are offered through our financing companies Lending Club and Care Credit. We have partnered with both companies to have a variety of options for our patients. A front desk coordinator can assist with the application process in office and brochures are available upon request.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment, we require, at minimum, a 2 business days' notice PRIOR to your reserved appointment for any changes or cancellations and to avoid a $25 cancellation fee per appointment. You may leave a message at any time, by calling (616) 457-2710. Starting August 1, 2019, there will be a $50 fee applied to the account for each appointment missed without a 2 business days' notice. We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first occurrence. We record all appointments, cancellations, and no-show appointments and discourage repeated abuse of our scheduling guidelines. If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these guidelines. These guidelines will enable us to better serve the needs of all patients.

By signing below, I have read and understand the above guidelines. I have the right to receive a copy of these signed forms upon request.

Signature of Patient or Guardian *Relationship (if other than patient)* *Today's Date*

(see other side)

Patient Name: DOB:

Notice of Social Security Number Privacy Policy

Privacy is important to our practice. We are required by law to maintain privacy of your Social Security number ("SSN") and to provide individuals with notice of our legal duties and privacy practices with respect to your SSN.

McMahon Family Dental ("we", "our") has adopted a Social Security Privacy Policy ("Policy"). That Policy provides information about how we may use and disclose your SSN. You may request a copy of the Policy at the front desk. We may change the terms of our Policy at any time. If we change our Policy, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of your SSN for our treatment, payment and health care operations and that you have had an opportunity to review the Policy. These policies are in compliance with the Michigan Social Security Privacy Act (MCLA 445.81, et. seq).

Authorization & Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize McMahon Family Dental to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or McMahon Family Dental's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, McMahon Family Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- McMahon Family Dental does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that McMahon Family Dental already sent before receiving my written instructions to stop.

By signing below, I have read, understand, and authorize consent to the above information. I have the right to receive a copy of these signed forms upon request.

Signature of Patient or Guardian *Relationship (if other than patient)* *Today's Date*

(see other side)