OUR FINANCIAL POLICY

Whether you are new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies. As a courtesy to you, we research your insurance plan so that we may provide you with all of the information you need regarding your treatment. However, the insurance agreement is between you and the insurance company. The financial obligation for dental treatment is between you and this office. We will make every effort possible to make you aware of your portion due prior to treatment; however, this may not always be possible as treatment may change during the course of an appointment.

For you convenience, in addition to cash or personal check, we also accept VISA, MASTERCARD, and DISCOVER. We also offer a third party financing program and several other financing options for your dental treatment. Please be aware that checks returned for insufficient funds will result in a $25.00 fee added to your account.

Please remember that we rely on you to notify us of any changes in your dental insurance policy. Please alert us at sign-in if you have any changes in your dental insurance policy.

As a patient with dental insurance, you will be responsible for the following:

- Services not covered by insurance
- Any co-payments due including deductibles and co-insurance (percentage that is your obligation).

As a patient without dental insurance, payment in full at the time of service unless prior arrangements have been made.

Please remember that the portion requested at patient check out is an estimate of benefits only. If you are responsible for any additional balances after the insurance has paid, we will notify you with a statement via mail. Payment in full is expected within 30 days from your first statement advising you of the balance due.

If your dental treatment will be handled through Workman's Compensation, we will bill the responsible insurance company directly for you. Generally, there is no balance due once a Workman's Compensation claim is paid. If treatment required is due to an accident, we will file to the accidental dental carrier; however, you will be responsible for any deductibles or co-payments that apply.

If you or a family member have dual insurance, we will file to both the primary and secondary insurance plans as a courtesy to you. You are responsible for any deductibles or co-payments if required.

Please do not hesitate to inquire with any questions you have regarding this policy.

The undersigned agrees, whether he signs as agent or as patient that in consideration of the patient, he hereby individually obligates himself to pay the account of the treating health care provider in accordance with the regular rates and terms of said providers. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and costs of collection. All delinquent accounts bear interest at the legal rate. The undersigned recognizes

that all treating health care providers furnishing services to the patient may send a separate statement or account from/for each such health care provider.

_____ Patient's Signature Date:_____

(If patient is a minor or unable to sign, the person accepting responsibility must sign below.)

By:_____ Relationship:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

> **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
>
> **Payment** means such activities as obtaining reimbursement for services, confirming coverage billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
>
> **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, which includes filing insurance claims both paper and electronically. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following fights with respect to your protected health information, which you can exercise by written request to the office manager:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures for family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to removeit.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means.

The right to inspect and copy your protected health information and to amend your protected health information and to receive an accounting of that information. The right to receive a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Columbus Family Dental Center
901 3rd Street
Columbus, IN 47201

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, however, 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 payments third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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 the organization at any time at the address above 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 or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

FOR OFFICE USE ONLY

I attempted to get the patient's signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES but was unable to do so as documented above.

Date: Initials: Reason:

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below:

Description of the specific information to be used or disclosed:

_____
_____

Person on entity requesting the information and authorized to make the requested use or disclosure:

_____

Recipient of the information:

_____

The information is being requested for the following purpose(s):

_____
_____

The authorization shall remain in effect from the date signed below until:
_____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above to attention: Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and no longer be protected by HIPAA.

I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

___ If this line is checked, I understand that I authorize you to bill and receive compensation from a third party for the use or disclosure of my information.

Patient Name:_____ **Signature:**_____

Relationship to Patient
(If signed by personal representative of Patient):_____**Date:**_____

COLUMBUS FAMILY DENTAL CENTER
DR. LAURA BRACKEN
901 3RD STREET
COLUMBUS, IN 47201
812-373-9912

ViziLite

In our continuing efforts to provide the most advanced technology and highest standard of care available to our patients, this practice is proud to announce the inclusion of ViziLite Plus exams as an integral part of our annual comprehensive oral screening program.

One person dies every hour from oral cancer in the United States - and the mortality has remained unchanged for more than 40 years. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **27% of oral cancer victims have no lifestyle risk factors.** According to the American Cancer Society, more women in the United States wil be diagnosed with oral cancer this year (1200 cases) than will be diagnosed with cervical cancer (< 10,000 cases), and there are as many cases of oral cancer caused by the human papilloma virus (HPV 16/18), a sexually transmitted disease, as there are HPV - related cases of cervical cancer.

Clinical studies have determined that using ViziLite Plus after the standard oral cancer examination improves the dental professional's ability to identify and evaluate suspicious areas at their earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Proven screening technologies such as mammogram, Pap smear, PSA and colonoscopy offer the same type of early detection of cancer. ViziLite Plus is an easy and painless examination that gives this practice the best chance to find any oral abnormalities you may have at the earliest possible stage.

Oral cancer risk by patient profile is listed below:

Increased Risk: Patients age 18 - 39
- sexually active patients (HPV 16/18)

High Risk: Patients age 40 and older; tobacco users younger than age 40

Highest Risk: Patients age 40 and older and lifestyle risk factors (tobacco use); patients with a history of oral cancer;

Dental insurance might not cover this advanced oral cancer screening as an addition to the standard visual examination. This office will provide you with a medical insurance form for you to use to file this procedure with your medical insurance.

This practice prescribes the ViziLite Plus exam for all patients at increased risk, high risk and highest risk for oral cancer (adult patients age 18 and older and tobacco users of any age). We will be performing the ViziLite Plus exam annually following the standard oral cancer examination of the oral cavity for a fee of $65.