Green Lake Dental Care
Dr. Sarah Fraker & Associates
8118 Green Lake Dr. N, Seattle, WA 98103
Phone: 206-525-4994 Fax: 206-525-2063

Patient: _____

Other patients/ family members covered by this agreement:

_____

1. What address should we use for your written communication?

_____

Address City State Zip Code

2. Please give the name & phone number of an emergency contact not living at your same household:

Name/relationship: _____

Phone: _____

3. Your phone numbers: Home: _____ Work: _____

Cell: _____

4. Appointment courtesy calls are usually made mid-morning.

What number should we use? _____

How early can we call? _____

5. Do we have your permission to:

Leave a message at your home number? _____ yes _____ no

Leave a message at your work number? _____ yes _____ no

Leave a message on your cell number? _____ yes _____ no

Discuss your medical condition with members of your household or family members?

_____ yes _____ no

If yes, with whom? _____ Relationship? _____

_____ _____

Signature of patient or responsible party *date*

Printed name of patient or responsible party: _____

GREEN LAKE
DENTAL CARE

We realize our patients are busy people. In an effort to simplify our communication with you we are using a service for text and email appointment reminders. Please provide us with the following information:

Patient or Resposible Party Name _____

Mobile Phone _____

Email _____

Alternative email _____

Signature _____

I **DO NOT** wish to receive communication via Text _____ Email_____

We protect your privacy and will never share this information with outside vendors. You may opt out of these options at any point shoud you not find them useful.

FINANCIAL POLICY

Green Lake Dental Care

We appreciate the opportunity to serve you. It is our goal to provide you with the finest care possible integrating your dental needs and desires. We also wish to help you fully understand our procedures, treatment, and payment expectations. Please feel free to ask any questions regarding these policies. Our staff is most willing to assist you.

To assure that your care comes first and payment arrangements second, our financial policy contains the following payment provisions.

For all treatments, payment is due at the time of your procedure for the portion not covered by insurance.

METHODS OF PAYMENT

Acceptable methods of payment are cash, check, Visa, MasterCard, Discover, and Care Credit.

INSURANCE

Your insurance plan (pre-paid dental plan) is a contract between your employer and the insurance company. You and the doctor determine your treatment requirements and your "insurance" helps pay for the services. As a courtesy, we will bill your insurance company for you if you have provided us with all the proper information. All co-payments are due and payable at the time of service. All amounts covered with your insurance are due within 60 days regardless of insurance involvement.

ESTIMATES

After the initial visit we can provide a written treatment plan with an estimate of total costs. Your treatment plan will also include a breakdown of fees, the estimated insurance coverage, and your portion due at each visit. We would like to emphasize that these are "estimates". Should additional procedures become necessary as treatment progresses, we will advise you of these additional fees.

For your appointment, we have blocked out the estimated time necessary <u>for you</u> with the dentist and staff. It is impossible to appoint another patient for your reserved time on short notice. We <u>reserve the right</u> to charge your account $130 per hour for appointments canceled or changed with <u>less than 48 business hours notice</u>. A minimum charge of $130 will apply. If you need to cancel or reschedule, please <u>call</u> the office, <u>do not text or e-mail cancellations</u>.

I certify that I have read the above policies. I understand them and agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Patient Signature_____Date_____

RELEASE OF RECORDS AND PHOTOS

I allow for release of my x-rays and records to my insurance company, as needed, in their payment of my dental claims. I allow for release of my x-rays and records to other dental and medical specialists as needed. I also allow for photographs to be taken of my mouth and dental work for the use of education and as a record of progress of my treatment.

Patient Signature_____Date_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Green Lake Dental Care
8118 Green Lake Dr. N
Seattle, WA 98103
(206) 525-4994

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependant family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refusal to sign
- Communication barriers
- Emergency situation
- Other

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 & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law 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 law, 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards, leaving messages at home and /or work, and e-mails. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to your. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. 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 certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to 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 remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice if effective as of April 9, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Noticed of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer
Green Lake Dental Care
8118 Green Lake Dr. N
Seattle, WA 98103
(206) 525-4994

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
877-696-6775 (toll free)

Green Lake
Dental Care

Sarah D. Fraker, DDS