**MARY HUFFMAN FAMILY DENTISTRY**
**918 BURKEMONT AVENUE**
**MORGANTON, NC 28655**
**(828) 430-8334**

**Notice of Privacy Practices**

Your privacy is very important to us. We promise to take every precaution to protect your rights, having your healthcare information secure. Our formal notice of privacy practices is posted in the waiting area. Please read this while waiting for your visit. Or you may ask for your copy of this notice, which is located at the front desk.

We also need to ask our patients how they wish to be notified about upcoming appointments.

Dr. Mary Huffman's office may call my home to confirm upcoming appointments and may leave a message on my answering machine if I am not available. **Yes** ____ **No** ____

**I authorize Dr. Mary Huffman to release my medical/dental information to my personal patient representative(s).**

**Name:**_____ **Relationship:**_____ **Contact #:**_____
**Name:**_____**Relationship:**_____**Contact #:**_____

I have read the posted notice and/or requested a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my teeth information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at the address above to obtain a current copy of the policy.

**Patient Consent**

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

- Conduct, plan and direct my treatment and follow-up amount to the multiple health care providers who may be involved in that treatment directly and indirectly.
- Contact third party payers such as an insurance company to verify benefits.
- Obtain payment from third party payers such as insurance companies.
- Conduct normal health care operations such as quality assessment and physician certifications.
- Contact me by phone for appointment reminders.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 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 do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____

Signature: _____
(Parents signature if a minor) Date: _____/_____/_____

Dr. Mary Huffman DMD, PA Family Dentistry

# Financial Policy

Payment for services is due at the time of treatment by one or more of the following:

- Dental Insurance (we accept & file most dental insurance)
- Cash, debit/credit card and checks
- Care Credit (a monthly payment plan that requires prior credit approval)

**Insurance**: Insurance is a contract between you and your insurance company. We are NOT a party to this contract; we will verify and file your primary insurance as a courtesy to you. ALTHOUGH WE MAY ESTIMATE WHAT YOUR INSURANCE MAY PAY, IT IS THE INSURANCE THAT MAKES THE FINAL DETERMINATION OF YOUR ELIGIBILITY. WE DO NOT GUARANTEE THE ACCURACY OF ANY ESTIMATE OF BENEFITS RELATING TO THE PATIENT'S PLAN OR RENDERED TREATMENT. YOU ARE RESPONSIBLE FOR PAYMENT OF ANY PORTION OF THE CHARGES NOT COVERED BY YOUR INSURANCE. Benefits are payable in accordance with the coverage in effect at the time treatment is actually rendered and are subject to plan maximums, deductibles, co-insurance factors and any other specific plan limitations. It is your full responsibility to understand the terms and payments at the time treatment is rendered.

**Returned Checks**: You will be charged a fee (currently $30 plus the banks fee) for any checks returned to us by your bank. Only cash or credit card payments will be accepted for future services or remaining account balance.

**Monthly Statement**: If you have a balance on your account for any reason, we will send you a monthly statement. Unless other arrangements are agreed to by us, the balance on your statement is due and payable by the indicated due date and will be considered past due if not paid by such time.

**Past Due Accounts**: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you may also be assessed a collection fee.

**I have read and agree to the above policy**

Patient's Name: _____

Responsible Party: _____
(If not the patient)