Fairfax Advanced Dentistry

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ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

PLEASE NOTE: Make sure that both pages of this document are completed by clicking the arrows at the top or bottom of the form and that you click "SUBMIT" at the end of the process

You may refuse to sign this form

I have read and recieved a copy of this office's : NOTICE OF PRIVACY PRACTICES

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Signature _____ **Date** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (specify)

HIPPA PRIVACY FORM

Acknowledgment of reciept of notice of privacy practices

This form is used to obtain acknowledgment of our notice of Privacy Practices or to document our good faith to obtain that acknowledgment.

Notice of privacy practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this notice to each patient beginning no later than the date of our first service delivery to the patient after April 14, 2003. We must make good-faith attempt to obtain written acknowledgment of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the notice. Whenever the notice is revised, we must make the notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Therefore, we must distribute the notice to each new patient at the time of service and to any person requesting a notice. We must also post the revised notice in our office as discussed above.

PHOTO AND DIGITAL IMAGES CONSENT

PLEASE NOTE: Make sure that both pages of this document are completed by clicking the arrows at the top or bottom of the form and that you click "SUBMIT" at the end of the process

Occasionally, we take pictures of your teeth, smile or entire face. We use them (or just keep them on file) for Insurance and for Liability reasons. Some of the dental cases are unique and some of them are very helpful for other patients to make the right decision regarding dental treatment. We do not sign your name under the images and we use them for internal office purposes only. By signing this form I agree to give Dr. Alexander Osinovsky, his associates and dental assistant permission to take and use photos and digital images of me free of charge and of my dental work for internal office use, website, promotional/marketing, laboratory and for educational purposes. I understand that I may revoke permission to use photographs / images at anytime by contacting in writing Fairfax Advanced Dentistry , personally Dr. Alexander Osionovsky, his associates or dental assistants.

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Signature _____ **Date** _____

DENTAL INSURANCE CLAIM PROCESSING POLICY

Because dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role. It is your dentist?s responsibility to recommend what you need. All recommendations are based on diagnostic (x-rays) and clinical picture presented to you by your dentist or by the office manager. Your dentist will give you options (if any) for the treatment recommended, will answer all questions you might have about it and will help you to decide what treatment would be the best for you. When your office visit is completed, the receptionist will enter the charges into the computer. You will be asked to pay an estimated amount for the service provided. Our estimate is a guess based on the information provided by the insurance representative over the phone. The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.

If you carry a supplementary or secondary Insurance Plan, we will help you with both Insurance claims, but we still will follow our policy to collect deductible, coinsurance, pre-payment. Your overpayment, if any, will be returned back to you after secondary claim will be cleared, in the form of original payment.

Initial to confirm that you understand the above information _____

If you are interested in following the doctor?s recommendation and need to know exactly how much your insurance plan will pay for it, a pre treatment estimate will need to be filed. We will file a patient treatment pre-estimate to their primary insurance upon the patient?s request before the treatment is begun.

Initial to confirm that you understand the above information _____

We will send a dental claim on your behalf and we will answer any questions your insurance company may raise about diagnosis or treatment in an appropriate, timely manner. It is important that you understand that we are not part of the relations between you and your insurance. If insurance denies benefits for patient?s treatment for any reason, the patient is financially responsible for all charges and for outstanding balance on the account. We are unable to ?force? an insurance company to fulfill its obligations to you. If the insurance company does not pay for your treatment in a reasonable period of time (more than 2 months) the patient is responsible to pay the balance off. All credits if any will be returned to the patient upon receiving final payment from the insurance.

Initial to confirm that you understand the above information _____

We would love to keep you happy and helping you to accept a recommended treatment by providing any assistance with your benefits. There is a way to help, but it does not include taking on total responsibility for the decisions of your insurance company.

I have read and understood the above information. I acknowledge that I am responsible for all charges incurred from services rendered by Fairfax Advanced Dentistry

Print Name _____ (Patient/subscriber, if minor have guardian sign)

Signature _____ **Date** _____