HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____ Date:_____

Signature of Patient and/or Guardian

_____

Relationship to Patient

I, _____, acknowledge and allow Blum-Nico Oral Surgery Associates to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call:

[ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR

[ ] you may e-mail me at _____ OR Text Me at: _____

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Blum-Nico
Oral-Facial Surgery Associates
ORAL SURGERY • DENTAL IMPLANTS • JAW RECONSTRUCTION

Financial Policy

Thank you for choosing Blum-Nico Oral-Facial Surgery Associates for your oral surgery needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable as possible for our patients by offering several payment options.

Payment Options

For your convenience, our office accepts several methods of payment. These include:

- Cash, Check, Wire Transfer, Visa, Mastercard, Discover, or American Express
- Third party financing from CareCredit and Lending Club are available (where our office pays the interest for you for select plans).[2]

These plans:

- Allow you to pay over time, some plans with NO INTEREST[1]
- Offer convenient, low monthly payment plans
- Have no annual fees or pre-payment penalties

Credit Card Processing Fee

For patients that choose to pay for treatment with a credit card, a 2.5% credit card fee will be added to their payment.

Scheduling/Cancellations/Late Patients

Our office requires full payment prior to the beginning of your treatment. A 50% deposit is required to secure your initial treatment appointment and the balance is due three days before the day of surgery or one week before if paying by check. If you choose to discontinue care before treatment is complete, you will receive a refund less incurred costs plus the cost of care received. **A 48 hour notice is required for schedule changes or to receive a refund of your deposit.** If you choose to cancel your surgery with less than a 48-hour notice, then you will be assessed a cancellation fee of $800 or your deposit amount (whichever is the lesser amount).

Our office has reserved specific surgery appointment times for you. As a courtesy we ask that you come to your surgery appointment on time. If you are going to be tardy, please call our office. If you are more than 15 minutes late, we will have to reschedule your appointment.

Dental insurance

Our office **does not participate** with any insurance company. However, for patients with dental insurance we are happy to file the necessary paperwork to your carrier to help you maximize your benefits and provide you with the documentation you need to receive reimbursement for your treatment. The patient is ultimately responsible for fees due to the practice regardless of insurance payment.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment you want and need in the most comfortable way possible. I have read and understand the financial policy above.

_____
Print Name

_____ _____
Patient/Guarantor Signature Date

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2]Subject to credit approval