Love Dentistry
www.love-dentistry.com
billing@love-dentistry.com

Consent for Treatment

I, the undersigned, herby authorize the doctor and her staff to take radiographs, study models, photographs or any other diagnostic aids the dentist deems necessary to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be deemed appropriate. I authorize and consent that the doctor employ any such assistance they may require. I agree to assume the risks associated with general dental treatment, which include but are not limited to the following:

- Reduction of tooth structure. In order to replace decayed or otherwise traumatized teeth, it is necessary to modify the existing tooth or teeth. Tooth preparation will be done as conservatively as practical. - Numbness following use of anesthesia. In preparation of teeth for restoration, anesthetics are usually needed. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues which is usually temporary; in rare instances, such numbness may be permanent. -Sensitivity of teeth. After the preparation of teeth, often they may exhibit sensitivity. It may be mild to severe. This sensitivity may last only for a short period of time or may last for much longer periods. If it is persistent, notify us so that we can determine the cause of the sensitivity and seek to treat that condition. - Longevity of restorations. There are many variables that determine how long restorations are expected to last. Among these are some of the factors mentioned in the preceding paragraphs, including patient cooperation, the general health of the patient, oral hygiene, regular dental checkups and diet. As a result, no guarantees can be made or assumed to be made regarding longevity of restorations. If you are unhappy with the treatment or are experiencing problems with a restoration, please notify the office. We want the best dental health for our patients and want you to be happy with the treatment that you receive in our office.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records for health purposes. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents regardless of insurance coverage. Breach of this responsibility caries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

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Cancellation Policy

Please understand that when we schedule your appointment, we are reserving time for your needs. We kindly ask that if you must change an appointment, please give us at least 48 business hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We understand there are times when it is unavoidable to make changes to your appointment and informing us as early as possible is greatly appreciated.

Our business hours are:
Monday 8:00 AM - 5:00 PM
Tuesday 10:00 AM- 5:00 PM
Wednesday 8:00M- 5:00 PM
Thursday 8:00 AM - 2:00 PM

We know that your time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule.

Please be aware that we will require a deposit to reserve an appointment in our schedule after the second missed appointment. The deposit amount is $50 per appointment hour that can be applied to treatment or refunded to you if you arrive to your scheduled appointment. This deposit is no longer refundable if your appointment is cancelled without 48 business hours' notice. After your third missed appointment the deposit amount will be the total cost of your visit. This deposit can be applied to treatment or refunded to you if you arrive to your scheduled appointment. If you are unable to make your reserved reappointment and fail to give 48 business hours' notice this deposit becomes non-refundable and you may be dismissed as a patient from our office, at the discretion of our providers.

I have read the above policy and will do my best to give sufficient notice if I need to make changes to my appointment. I am aware that I may be required to place a deposit to reserve an appointment if I make short notice changes or no show frequently without 48 business hours notice.

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Financial Policy

We appreciate the trust you have placed in us and would like to thank you for choosing our practice for your upcoming dental work.

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, American Express, Care Credit third party financing, personal check, money order, or registered check. If check returned for nonsufficient funds (NSF) you will be charged $25 and is due upon the receipt.

To avoid any confusion, we kindly request that payment arrangements be made prior to beginning your treatment.

Regarding Your Insurance Benefits:
Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We feel that dental insurance can be a great benefit for many patients. We work 100% for YOU and want to help you maximize your benefits. However, the treatment we recommend will always be based on your individual need, not your insurance coverage. The ultimate decision as to what will be done and how fast we proceed will always be made by you.

If you would like to utilize your insurance benefits, we will gladly assist you with filing your claim and sending any additional information necessary. However, please understand that it is impossible to estimate exactly what your insurance company will pay for your treatment.

Any balance not paid by your insurance company is ultimately your responsibility and is due within 30 days of our statement. A finance charge of 1.5% will be applied on all accounts greater than 30 days past due.

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This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please Review it carefully.

Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you and others involved in the continuation of your dental/medical care.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities. We may also contact you regarding your dental/medical care, via specified phone or cell phone, work phone, texting, faxing, e mail or traditional, by way of US Post Office or any other authorized courier.
Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual involved in the continuation of your dental/medical care, regarding specific care, treatment or payment. Additionally, we may disclose information about you to a patient representative. If a person has the authority

by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
o Prevent or control disease, injury or disability;
o Report child abuse or neglect;
o Report reactions to medications or problems with products or devices;
o Notify a person of a recall, repair, or replacement of products or devices;
o Notify a person who may have been exposed to a disease or condition; or
o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic
violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to
the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please Contact:
Aimee T Werremeyer, DMD
4101 Eliza Avenue
Bellingham, WA 98226
360-752-1600

If we cannot resolve your complaint you have the right to file a complaint with the Secretary of the department of Health & Human Services (HHS) Office for Civil Rights, 2201 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will You be penalized for filing a complaint.

If there is someone that you allow us to speak to on your behalf regarding financial and or health information please list their name and relationship to you:

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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 healthcare 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. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule

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 then you are bound to abide by such restrictions.

I understand with my signature I grant my permission to you and your assignees, to contact me to discuss this statement or my treatment, as well as agreeing to your cancellation and financial policy.