DR. Kinnar R Shah DMD PA
121 Waterman Ave, Mt Dora, Florida 32757
Phone: (352)735-0738 Fax: (352)735-0751
Email: mydentistinmtdora@gmail.com

GENERAL CONSENT FOR DENTAL TREATMENT

Patient's Name: _____

Birthdate: _____/_____/_____

I give consent for myself/my child to receive dental treatment deemed necessary by the Dr. Kinnar R Shah DMD / providers at the Kinnar R Shah DMD PA. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, tooth extractions, and the use of local anesthetics with or without sedation/anxiolysis.. I understand that the use of local anesthetics carries a small risk for swelling,, bruising,, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information.

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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Dr. SHAH DMD

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Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

_____

Signature of Patient / Responsible Party Print Name Date

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PAYMENT / FINANCE POLICY

The patient and/or legal guardian are responsible for paying all deductibles and estimated co-pays at the time of service. We may collect a deposit to reserve an appointment longer than one hour.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility / payable benefits. Keep in mind dental insurance is not designed to provide 100% benefit, but rather it is meant to assist you with the cost of dental care.

As a courtesy to our patients, we electronically bill your insurance company as a courtesy to you. Please allow 4-6 weeks for claim processing. As the patient and/or responsible party, you are responsible for the remaining account balance after insurance processes the claim. Any services benefited by insurance, after insurance has paid, will be refunded back to you in the form of a check to the insurance subscriber

If your insurance company requires a preauthorization or you would like to know your exact insurance benefits, you are responsible for notifying Kinnar R Shah DMD PA PRIOR to any dental treatment being performed. This does delay treatment but will give you the exact out-of-pocket expenses you may require. Failure to obtain this information may result in limited payment or NO payment from the insurance company.

Here at Kinnar R Shah DMD PA, we would be happy to provide a courtesy benefits check for common dental procedures for you. However, we always encourage you to call your insurance company before your treatment appointment to verify your eligibility / benefits information.

Appointments Missed

A $50 fee may be added to your account for each appointment canceled without 24 hours' notice, missed, or failed.

Outstanding Balances

• A 1.5% monthly (18% annually) finance charge will be imposed for balances due over 30 days.

A $50 returned check fee will be imposed for insufficient funds if remaining account balance is paid with check.

In the event of default on your account, we reserve the right to refer your account to a collections agency. Appropriately, the patient and/or responsible party will be responsible for all collection costs and legal fees that incur during the collections process.

_____

Signature of Patient / Responsible Party Print Name Date