

**Patient Acknowledgment of
Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices**

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPPA_ requires, effective April 14, 2003, that patients be give a copy of our Notice of Privacy Practice.

If you would, please PRINT and SIGN you name bellow,

I, _____, acknowledge I have received from this office.
(If you do not want a copy of either sheet, please inform the front desk personnel)

1. A copy of the Dental Materials Fact Sheet, and
2. Notice of Privacy Practices

Patient or Guardian Signature

Date

If signed by a Personal Representative of the patient, describe the representative's authority to act for the patient.

- 1) Returned Checks:** There will be a \$25 fee for all returned or stopped checks after services are rendered
- 2) Missed/Cancelled appointments:** A missed appointment or late cancellation fee of **\$50 per scheduled hour** will be assessed for any notice **less then 48 business hours**. This will be waived 1 time for emergencies only and by Dr. Pham's discretion.
- 3) Pre- Authorizations:** Progressive Dental Arts will do Pre-authorizations for any and all treatment that needs to be completed, but only when requested by the patient, there will be a \$25 fee that will be put towards the payment for the services rendered.
- 4) X-ray/Record Duplication:** We are more then happy to send digital images to other dental specialists. There will be a **\$25** fee for x-ray/record duplication.
- 5) Insurance Patients:** As a courtesy, we file your insurance for you and allow 30 days for insurance payment on your account. On the day of service we will collect only a portion of the fee charged for the services rendered. Any balance left on the account after the insurance payment is received is the responsibility of the financial guarantor.

I the undersigned, certify that I have read, understand and agree to abide by the above policies.

Patient or Guardian Signature

Date

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

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

Photograph Authorization

I hereby give my consent for Dr. _____ to take photographs, slides and/or videotape of _____ (patient's name) face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

Please initial:

- _____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.
- _____ I consent to the use of my photographs, slides, and/or videotape **ONLY** for laboratory use.
- _____ I **DO NOT** consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

Patient's or Legal Guardian's/Representative's Signature

Date

Dentist's Signature

Date

COPY OF THIS SIGNED DOCUMENT TO PLACED IN PATIENT'S CHART