Patient Financial & Appointment Policy

To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about this policy, please discuss them with our Business Office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and satisfaction.

All co-pays, deductibles, and fees for non-covered services are due at the time of service. A $15.00 billing fee will be added to your account if you do not pay this by the end of the day of service. If you do not have insurance, full payment is due at the time of service unless prior arrangements have been made. All dental plans are not the same and do not cover the same services. You need to contact your insurance company/employer prior to your appointment if you have any concerns about what is covered under your plan.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

There will be a service charge of $25.00 on all returned checks.

In the event we are forced to send your account to a collection agency for nonpayment, you agree to pay all cost of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 35%. Such fees will be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

Your insurance policy is a contract between you and your insurance company. The doctor is not involved. However, as a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.

To provide the best possible service and availability to all our patients, we ask that you please notify our office 24 hours in advance of your scheduled appointment time if you are unable to keep your appointment. We realize that emergencies occur, but we ask for your assistance in this regard. After 2 broken (no show) appointments you will be dismissed from the practice.

By signing the Patient Financial & Appointment Policy, you are stating that you are responsible for any services performed by this practice. You agree any balance not paid by the insurance is your responsibility and will be paid upon receipt of your first statement unless other arrangements have been made.

_____ _____

Signature of Patient or Responsible Party Date

Consent for Dental Treatment

_____ _____

Patient's Name *Date*

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ 1. TREATMENT:
I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, impacted tooth removal, Root Canals, treatment of periodontal disease or other work deemed necessary. I also understand that the dental hygienist may see me once a year in the doctors' absence. I understand that sometime in the future I may be offered an appointment for dental hygiene services when a doctor is not present.

_____ 2. DRUGS AND MEDICATIONS:
I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions, resulting in redness and swelling tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. RISKS OF DENTAL ANESTHESIA:
I understand that pain, bruising, and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue, or associated facial structure can occur with "shots." About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possible treatment may be needed if the symptoms do not resolve.

_____ 4. FILLINGS:
I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

_____ 5. CROWNS, BRIDGES, INLAYS AND ONLAYS
I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand that I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

_____ 6. DENTURES
I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related problems such as: shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time and there are a small number of patients who never do. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustments and one or more relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is required due to my delay, additional fees may be incurred.

_____ 7. EXTRACTIONS:
Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to, pain swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____ 8. PERIODONTAL DISEASE:
Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____ 9. ROOT CANAL THERAPY:
I realize root canal therapy has a very high success rate; however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include extensive decay making the tooth unrestorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough may need further surgery or treatment by a specialist at additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise, and any costs incurred are my responsibility. After root canal therapy, a crown is needed which, if not placed right away, might lead to fracture of the tooth and possible extraction.

_____ 10. CHANGES IN TREATMENT PLAN:
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during treatment.

CONSENT: My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____ _____

Patient's or Guardian's Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/16/02 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. We reserve the right to make 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

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 provide performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

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 and Friends: We must disclose health information to you, as described in the Patient Rights Section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 us 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, or 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.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $5 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the past 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make you request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Maegan Holmes
Telephone: 270-247-1966 Mayfield Office (270) 444 – 6080 Paducah Office Fax: 270-247-5471 Mayfield Office or (270) 444-6033 Paducah Office
E-mail: freemandentalpllc@gmail.com
Address: 312 Wyatt Drive 4616 Village Square Drive
Mayfield, KY 42066 Paducah, KY 42001

Please sign below to acknowledge receipt of Notice of Privacy Practices:

_____
Please Print Name

_____
Signature

_____
Date

THIS IS FOR OUR RECORDS. IF YOU WOULD LIKE A COPY OF THIS NOTICE TO TAKE HOME WITH YOU, PLEASE REQUEST ONE FROM THE RECEPTIONIST.

For Office Use Only

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 the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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