CLOVERLEAF
DENTAL CENTER, LLC

1064 E. Main St. Suite 102., Meriden, CT 06450
(203)634-8727 F (203) 634-3643 www.cloverleafdental.com

PATIENT AGREEMENT

Patient Name: **Date:**

1. **Payment for services rendered** by Cloverleaf Dental Center, LLC, is due and payable in full at the time services are rendered unless prior arrangements have been specifically made.
2. **Any balance unpaid after 60 days** from the date services were rendered will be subject to interest at the annual percentage rate of 18%.
3. **Cloverleaf Dental Center, LLC, charges** a $50 No Show Fee for same day, or less than 24 hour, cancellations and for missed appointments and a $150 for Specialist. After 3 consecutive missed appointments Patients will be dismissed from our practice.
4. **In the event** the Patient submits payment by check and that check is returned for any reason by the Bank, Cloverleaf Dental Center, LLC, may add to the balance owed by the Patient or Responsible Party the bank's applicable overdraft charge and/or a $25 service fee.
5. **For patients with insurance**: Any cost sharing, such as co-payments, coinsurance and/or deductibles are the responsibility of the Patient and/or Responsible Party. In the event that services are not covered, Patient and/or Responsible Party shall be responsible for payment in full for those services.
6. **In the event** Cloverleaf Dental Center, LLC, brings any action to collect payment owed for services rendered, Patient and/or Responsible Party shall be liable for all costs of collection to include reasonable attorney fees and/or collection agency fees.

Authorization for Release of Dental Records

Authorization is hereby given to Cloverleaf Dental Center, LLC, *to submit my claim directly to my insurance company on my behalf. I understand that by signing this form I am authorizing the release of my medical/dental and billing information to secure payment from any insurance carrier and that my signature is not needed each time a claim is submitted. I further authorize my insurance carrier to forward payment directly to Cloverleaf Dental Center, LLC.*

I have read and fully understand all the above conditions. By signing this Agreement, I accept that I am responsible for all payments, charges, and if necessary, costs of collection as stated above.

Patient or Responsible Party's Signature: **Date:**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or healthcare operations. I also understand 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 that telephone messages may be left on my machine with regard to test results and/or reminder of my appointments.

Patient Name:

Signature of Patient or Legal Guardian:

Date:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date Initials: Reason:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1997 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

Treatment means providing, coordinating and managing healthcare and related services by one or more healthcare providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and improvement activities and utilization.

Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by your written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Practice.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree, in writing, to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us, upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the U.S. Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.