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:**

Thank you for choosing Cloverleaf Dental Center LLC as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

1. **Payment for services rendered** by Cloverleaf Dental Center, LLC, is due and payable in full at the time services are rendered. Our office accepts cash, personal checks, Visa/Mastercard/Discover/American Express, Care Credit, and Lending Club. We also offer interest free 12 month financing with both Care Credit and Lending Club. If your treatment requires a payment that exceeds $1500, it must be paid with either a debit/credit card or bank/cashiers check.
2. **Missed or appointments cancelled less than 24 hours:** We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all our patients. We want you to know that we make every effort to see you at your scheduled appointment time. We feel that a successful outcome to treatment is the result of combined efforts of both you and this office. Therefore, it is important to adhere to the recommended treatment schedule to obtain optimum results. If you must cancel or reschedule an appointment, we would greatly appreciate that you notify us at least 24 hours prior to your scheduled time. Broken or missed appointments, or notification less than 24 hours, as well as late arrivals create scheduling problems for other patients as well as the practice. Appointments are considered reservations and you will receive a reminder email/text or call prior to the appointment as a courtesy. If we are unable to reach you, we trust that you will keep your reserved appointment. Repeated late cancellations or missed appointments will force us to double book your appointment and institute a fee of $50 with our general clinical staff or $150 for our specialist, and possibly a dismissal from the practice. We ask for your careful consideration regarding this matter. In return, we promise to provide you with the very best dental care.
3. **Returned Checks:** In the event that 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.
4. **For patients with insurance**: If you have insurance benefits, as a courtesy to you, we ask that you pay the deductible or the estimated co-payment at the time of service. As a courtesy to our patients, we will submit the insurance claims for you; however, your insurance is a contract between your employer, the insurance and you. All patients are financially responsible for their accounts.
   The insurance company is responsible to the patient. We want to emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. All charges you incur are your responsibility regardless of your insurance benefits. We will cooperate fully with the regulations and requests of your insurance

carrier that may assist in the claim being paid. If problems arise in getting a claim paid, specific questions should be directed to your insurance carrier or your employer. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 45 days, we may ask that you contact your insurance carrier to make sure payment is expected. If payment is not received within 90 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payments from your insurance company after you have paid your bill in full, we will remit the payments directly to you.

5. **Collection Recover:** Any balances paid after 60 days, may be subject to an annual interest rate of 18%. In the event that Cloverleaf Dental Center, LLC, brings any action to collect payment owed for services rendered, the Patient and/or Responsible Party shall be liable for all costs of collection to include reasonable attorney fees, interest 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 also read, understand and agree to the above terms and conditions regarding the financial and appointment policy for this practice.*

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.