Dr. David Porter, DDS
Synergy Dental Center
501 W Lakeway Rd
Gillette WY 82718

307-682-3100

PRACTICE POLICIES AND TREATMENT CONSENT

Welcome to Synergy Dental Center! Our goal is to provide you the highest quality dental care; we are confident that is your goal as well. Please take the necessary time to review the following policies that will guide us to our mutual goal. After reviewing these policies, please feel free to ask us any questions.

PATIENT ACCOUNTS

FILING INSURANCE: As a courtesy to our patients, Synergy Dental Center will file any patient's primary/secondary insurance. To file your insurance, we require the ***social security number*** of the policy holder and responsible party (these may not always be the same person). Any price quote given by Synergy Dental Center will always be an ***estimate***. Your insurance company has final determination of your benefits.

PAYMENTS: Payment is due in full at the time of the appointment. If we file your insurance, Synergy Dental Center will extend you credit for your estimated insurance benefits and require that you pay the remaining balance on the date of service. By extending you credit for the estimated insurance and waiting for insurance reimbursement, Synergy Dental Center allows you to keep more money in your pocket for routine expenses. However, if your insurance company does not assign us benefits, you will be responsible for any services rendered the day of the service and your insurance will reimburse you. We accept Master Card, Visa, Discover, American Express, Care Credit, Checks, and Cash. Any claims outstanding greater than 90 days will be billed to the responsible party. Balances outstanding more than 60 days will be charged interest of 18% APR. If payment is by check, we would like you to be aware that checks with insufficient funds associated with them will be a charge of $30.00 reflected on your account. You will have 30 days to pay the total cost of the check and the fee.

PATIENT APPOINTMENTS

EXCELLENT PATIENT CARE: Synergy Dental Center will make every attempt to reserve the sufficient time necessary to deliver the highest quality dental care possible to you. Please arrive on time to your appointments, so that you will be able to take full advantage of your reserved time. If you arrive over 15 minutes late for your appointment, we may reschedule the appointment to allow sufficient time for excellent patient care. Consistent or excessive lateness may result in dismissal from the practice. Treatment appointments made that ***exceed $500 will require 10% down*** to hold the appointment time.

"DIS-APPOINTMENTS": Synergy Dental Center will be "disappointed" if you are unable to keep a scheduled appointment. Please notify our office and reschedule as soon as possible. If you fail to notify our office within 48 hours prior to the scheduled appointment, a sixty-five dollar ($65) fee will be charged. Consistent or excessive "dis-appointments" may result in dismissal from the practice.

CONSENT: I have read and understand all the above information. The undersigned hereby authorizes the doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation deemed necessary. I f I ever have any change in my health or change in my medication; I will inform the doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the doctor and authorizes the release of dental records to my insurance company.

_____ _____

Patient Name: Date:

_____ _____

Patient/Guardian Signature: Relationship to Patient:

Dr. David Porter, DDS
Synergy Dental Center
501 W Lakeway Rd
Gillette WY 82718

307-682-3100

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

This is a shortened version of the HIPPA policy. The full policy is available for your review in the reception area.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Patient Name: Date:

_____ _____

Patient/Guardian Signature: Relationship to Patient: