Dr. Howard A. Mendelsohn & Associates

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

The "**Notice of Privacy Practices**" provides information about how **Dr. Howard A. Mendelsohn & Associates** may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions but if we do, we are bound by our agreement with you.

*By initialing below, you acknowledge receipt of our **Notice of Privacy Practices.***
Initial _____

Consent for Use and Disclosure of Information

By initialing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Insurance benefits be made on my behalf to **Dr. Howard A. Mendelsohn & Associates** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Insurance Carriers for which I have coverage, and information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.
Initial _____

I understand that I may request a copy of your Privacy Practices Policy at any time. I understand that I may revoke any and/or all authorization at any time, provided that the revocation is in writing to the Privacy Officer for this practice. I understand that I must put in writing any changes that I want made to my Protected Health Care Information and submit it to the Privacy Officer for this practice. Information pursuant to this authorization may be subject to re-disclosure by the recipient and no longer is governed by HIPAA privacy rules. I have the right to access my protected health information to be used or disclosed. I may receive a copy of this completed and signed authorized form.

MEDICAL RECORDS FAX/ELECTRICAL TRANSMISSION AUTHORIZATION

I understand that you may be transmitting my medical records electronically and authorize you to do so. If another party in error receives the transmission, I absolve Dr. Howard A. Mendelsohn & Associates of any and all liability to such submissions of said records.
Initial _____

COMMUNICATION AUTHORIZATION

I authorize Dr. Howard A. Mendelsohn & Associates to contact me and/or leave notification about my appointments, using the following means of communication. **(please initial next to choices)**

_____ **Cellular Phone** _____ **Home Phone** _____ **Work Phone**

Print: _____ **Sign:** _____

Date: _____/_____/_____

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, or Discover Card, as well as Care Credit. If you are unfamiliar with Care Credit, please ask one of our staff members for information. On delinquent accounts, the undersigned agrees to pay all costs of collection, including an attorney's fee of 33 1/3 % of the outstanding balance.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance, providing you furnish us with your benefits booklet outlining your dental package. You must realize, however, that:

1. Your insurance is ***a contract between you, your employer, and the insurance company.*** We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of "UCR". This statement does not apply to companies who reimburse based on an arbitrary "Schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand I am responsible for any charges I incur whether or not I have dental insurance.

Signature _____ **Date** _____