Easy Dental Care - 10/27/2022

Patient(s) name:

Financial Agreement

Insurance and Financial Policy

At Easy Dental Care, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know: A.) Your dental benefits are based upon a contract made between your employer and your insurance company. IF YOU HAVE ANY QUESTIONS REGARDING YOUR DENTAL BENEFITS PLEASE CONTACT YOUR EMPLOYER OR INSURANCE COMPANY DIRECTLY. DENTAL BENEFIT PLANS WILL NEVER PAY FOR COMPLETION OF YOUR DENTAL CARE. IT IS ONLY MEANT TO ASSIST YOU. B.) We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service.) This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require. C.) We will bill your insurance as a courtesy. If insurance does not pay within 90 days, EASY DENTAL CARE reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. D.) Easy Dental Care does require payment in full for your portion at the time of service. We accept Mastercard, Visa, American Express, Discover, Cash and Checks (for existing patients with established payment history). WE DO NOT ACCEPT CHECKS FOR OVER $500.00 FOR ANY PATIENT. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. E.) Any balances that insurance has not paid will be invoiced no more than two times. If your balance is not paid within the two billing cycles your account will be sent to a national collection agency. In an effort to defray the costs of collection proceedings, all accounts sent to collections would have a 25% charge added to the balance based on the unpaid invoice. F.) We do reserve time for your appointment and would appreciate at least 24 hours notice if you are unable to keep your appointment of your appointment or no show at the time of your appointment, there will be a cancellation / no show charge of $50 to cover the expense of reserving that time for you. This charge must be paid before we can schedule another appointment for you. G.) In the event of an emergency after regular business hours an EMERGENCY FEE will be charged for established patients in addition to the necessary treatment fees.

Signature

Date Signed:

Notice of Privacy Practices

Notice of Privacy Practices

<h4 data-bind-id="bs-db-776">Your Information. Your Rights. Our Responsibilities.</h4>

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW CAREFULLY. I acknowledge having received a copy of this office's Notice of Privacy Practices. (You May Refuse To Sign This Acknowledgement)

<h4 data-bind-id="bs-db-778">YOUR RIGHTS</h4>

WHEN IT COMES TO YOUR HEALTH INFORMATION, YOU HAVE CERTAIN RIGHTS. This section explains your rights and some of our responsibilities to help you. GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. ASK US TO CORRECT YOUR MEDICAL RECORD. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. REQUEST CONFIDENTIAL COMMUNICATIONS. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. ASK US TO LIMIT WHAT WE USE OR SHARE. You can ask us NOT to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. GET A COPY OF THIS PRIVACY NOTICE. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. CHOOSE SOMEONE TO ACT FOR YOU. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/. We will not retaliate against you for filing a complaint. I acknowledge having received a copy of this office's Notice of Privacy Practices. (You May Refuse To Sign This Acknowledgement)

<h4 data-bind-id="bs-db-780">YOUR CHOICES</h4>

FOR CERTAIN HEALTH INFORMATION, YOU CAN TELL US YOUR CHOICES ABOUT WHAT WE SHARE. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. Contact you for fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. IN THESE CASES WE NEVER SHARE YOUR INFORMATION UNLESS YOU GIVE US WRITTEN PERMISSION: Marketing purposes. Sale of your information. Most sharing of psychotherapy notes. IN THE CASE OF FUNDRAISING: We may contact you for fundraising efforts, but you can tell us not to contact you again. I acknowledge having received a copy of this office's Notice of Privacy Practices. (You May Refuse To Sign This Acknowledgement)

<h4 data-bind-id="bs-db-782">OUR USES AND DISCLOSURES</h4>

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?We typically use or share your health information in the following ways. TREAT YOU: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. RUN OUR ORGANIZATION: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. BILL FOR YOUR SERVICES: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/orc/privacy/hipaa/understanding/consumers/index.html. HELP WITH PUBLIC HEALTH AND SAFETY ISSUES: We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety. DO RESEARCH: We can use or share your information for health research. COMPLY WITH THE LAW: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. RESPOND TO ORGAN AND TISSUE DONATION REQUESTS: We can share health information with a coroner, medical examiner, or funeral director when an individual dies. ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS: We can use or share health information about you: For workers' compensation claims. For law enforcement purposes or with a law enforcement official. With health oversight agencies for activities authorized by law. For special government functions such as military, national security, and presidential protective services. RESPOND TO LAWSUITS AND LEGAL ACTIONS: We can share health information about you in response to a court or administrative order, or in response to a subpoena. I acknowledge having received a copy of this office's Notice of Privacy Practices.(You May Refuse To Sign This Acknowledgement)

<h4 data-bind-id="bs-db-784">OUR RESPONSIBILITIES</h4>

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. CHANGES TO THE TERMS OF THIS NOTICE: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. EFFECTIVE 05/01/2014. THIS NOTICE OF PRIVACY PRACTICES APPLIES TO THE FOLLOWING ORGANIZATIONS. Easy Dental Care, (703) 753-8600. easydentalva@gmail.com. I acknowledge having received a copy of this office's Notice of Privacy Practices. (You May Refuse To Sign This Acknowledgement)

<h4 data-bind-id="bs-db-786">ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</h4>

I acknowledge having received a copy of this office's Notice of Privacy Practices by signing below. (You May Refuse To Sign This Acknowledgement)

Signature

Date Signed

Appointment Agreement

Appointment Agreement

At Easy Dental Care, we understand that your time is valuable. We strive to see all our patients on time for their scheduled appointments, If you arrive more than 15 minutes late to your appointment, you may be asked to reschedule for the next available appointment time. If you must cancel your appointment and it is done in less than 24 hours, this will result in a $50 missed appointment fee. This fee must be paid before a new appointment is scheduled. Having three or more missed appointments may result in your dismissal from the office as a patient. If at any time you have questions, please feel free to ask our staff. We are here to help you in any way we can. Thank you for entrusting us.

Signature

Date Signed

COVID-19 Dental Treatment Consent Form

COVID-19 Dental Treatment Consent Form

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-urgent dental care is not

recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months I confirm I am seeking treatment for a condition that meets these criteria. I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below: Fever Shortness of Breath Loss of Sense of Taste or Smell Dry Cough Runny Nose Sore Throat. I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

Signature

Date Signed: