ACHARYA
PERIODONTICS & DENTAL IMPLANTS

OFFICE POLICIES

PATIENT CONSENT & AGREEMENTS

Authorization and Release Agreement

All patients or guarantors (if the patient is a minor) are responsible for the full payment of services rendered by Acharya Periodontics and Dental Implants. By signing this agreement, I agree to pay at the regular rates and terms of Acharya Periodontics and Dental Implants and any remaining balance due after my insurance company processes my claim(s) and makes payment or in some cases denies my claim and does not make a payment. I accept full financial responsibility, regardless of insurance coverage, for the treatment provided. I authorize and request that my insurance company remits payments directly to Acharya Periodontics and Dental Implants. I agree to present my insurance card at the time of my appointment along with any information required and necessary for any insurance claims to be filed. I authorize Acharya Periodontics and Dental Implants to release my diagnosis, records, treatment notes, x-rays, and any other information pertaining to my treatment or exams to a third-party payer and/or health practitioner whenever necessary. **I acknowledge if I give incorrect insurance or no insurance information that I will be responsible for submitting to my insurance company on my own and I will be responsible for my full out of pocket expenses at the time of service**.

Financial Agreement

I understand that if the account becomes delinquent (balance still due more than 60 days from the date(s) of service), a finance charge of 1.5% per month (18% annually) will be added to my account, and I will be responsible for paying the amount of these accruing finances charges until my account is settled and at a zero-dollar balance.

In the event that my account is turned over to a collection agency, I agree that I will be responsible for a fee equal to 35% of my outstanding balance due at the time my account is turned over for collection. For Acharya Periodontics and Dental Implants to service my account or to collect any amounts I may owe, I authorize the office, as well as any affiliates, which includes debt collectors, to contact me at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact include but are not limited to the use of pre-recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders, and facsimile as applicable.

Acharya Periodontics and Dental Implants is in-network with Delta Dental.
As a courtesy, our office will submit to all insurance companies, regardless of if we are in or out of network, with the exception of Medicare and Medicaid. I understand my estimated coinsurance will be collected for services rendered on the day of service. In the case of overpayment, I will be issued a refund in the form of a check. Our office accepts payments by cash, check, Visa, MasterCard, and Discover. Our practice does not accept American Express.

Cancellation Policy

I understand scheduled appointments that I do not appear for, or I cancel less than 48 hours before my appointment time with Acharya Periodontics and Dental Implants it will be considered a "No Show" and a $25.00 charge will be added to my account for each of these occurrences. Scaling and root planing and all surgical appointments that are "No Show" or changed within 48 hours will be subject to a $50 fee. **If appointments are not confirmed by 12:00pm the day prior it will be canceled.**

Dental Treatment Consent

I acknowledge that no guarantee or assurance has been made by anyone regarding my dental treatment other than Acharya Periodontics and Dental Implants' guarantee to stand behind the work they provide and in the event the patient is dissatisfied with services rendered. I understand that I have the right and opportunity to ask questions regarding my treatment, and that Acharya Periodontics and Dental Implants will answer any questions I may have.

I understand that proposed treatment may change based on conditions found during treatment that were not visible during the initial examination. I also understand that the treatment rendered may be different than traditional treatment due to considerations of the patient's age, medical condition, and out of office treatment environment. I understand the risks of refusing and not having recommended treatment performed. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending doctor for diagnostic purposes or treatment. I give my consent and authorization for Acharya Periodontics and Dental Implants, as well as assigned associates to provide treatment to the named patient below.

HIPAA Policy Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)

I understand I have the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

My signature below indicates that I have read, understand, and agree to all above policies and agreements for Acharya Periodontics and Dental Implants.

Patient/Responsible Party Signature: _____ Date: _____