Kuljic, DDS & Team "making your smile natural"
(978) 922-4200

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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Kuljic, DDS & Team **AND YOUR INSURANCE PLAN - HOW THEY WORK TOGETHER**

The staff at ***Kuljic, DDS & Team*** is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the following information regarding our insurance claims processing policies so that we can work together to best utilize your benefits.

DO YOU ACCEPT MY INSURANCE?/HOW MUCH WILL THEY PAY?

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 services*). This means that we work with literally thousands of companies. Although we can maintain computerized history of payment by a given company, they do change, and 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 exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figure you may require.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We base the patient portion of your bill on our most current data although there are many factors that can affect this estimate. There may be a deductible (*individual or family*) or you may have received treatment in another office prior to joining the ***Kuljic, DDS & Team***, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (*and cannot in most cases*) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly. Also, information given by insurance representatives over the phone is not a guarantee of payment or guaranteed to be accurate. Since it is your insurance plan it is also your responsibility to be familiar with all aspects of your individual plan.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, ***Kuljic, DDS & Team*** 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 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.

FINANCIAL OPTIONS

Kuljic, DDS & Team does request payment in full for your portion at the time of service. Beside ATM Debit Cards (which are run like a credit card-no pin needed), we also accept MasterCard, VISA, American Express and Discover. If you are in need of an extended finance option, we also work with Care Credit and Springstone, who offer low monthly payments with possible low fixed interest rates for those who are eligible. These plans and their benefits are designed to help meet your treatment plan needs. Just ask one of the patient service staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Kuljic, DDS & Team.

_____ _____

Signature Date