Rau Family Dentistry

We would like to express our appreciation for your business. We strive to provide the highest quality dental care to our patients with compassion and integrity. We would like to inform you of some changes in our office procedures. These changes will help us to provide better service to all our patients.

Confirmation of Appointments:

We have made changes to our automated reminder system in an effort to help keep you informed of your appointments with our office. You will receive a reminder email 7 days before your appointment and a text and/or phone call 2 days before your appointment. Please be aware that you can confirm your appointment by replying to the email or text. **If you do not cancel your appointment within 24 hours or do not show for your scheduled appointment you will be charged a fee of $50.00 per occurrence.** Please fill out the information below so that your reminders go to the accounts of your preference.

Email: ____

Cell: (____) _____-__________

Land Line: (____) _____-__________

Fees and Payments:

We make every effort to keep down the cost of your dental care. It is our policy that co-payments are paid at the time of your appointment. If you do not have dental insurance your payment is due at the time of service. For your convenience we accept Visa and MasterCard.

Insurance:

Your insurance contract is an agreement between you and your insurance carrier. We do participate with most major insurance carriers. As a service to you, our office will bill your insurance company. As required by most insurance carriers, you are responsible for the payment of deductibles, co-payments and any non-covered services at the time of your office visits.

*****PLEASE REMEMBER ALL PRE-AUTHORIZATIONS AND CO-PAYMENTS ARE ESTIMATES. YOU ARE RESPONSIBLE FOR ANY FEES NOT PAID BY YOUR INSURANCE CARRIER. *****

____ ____/____/________

PATIENT SIGNATURE DATE

PATIENT HIPAA INFORMED CONSENT FORM

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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given 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 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.

Patient Name (Printed): ____

Signature ____

Date: ____/____/________

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