SILICON VALLEY DENTAL CENTER
WISDOM TEETH · DENTAL IMPLANTS & SEDATION DENTISTRY

SILICON VALLEY WISDOM TEETH
THE EXPERTS IN WISDOM TEETH REMOVAL

Appointment Cancellation Policy

Dear Valuable Patient,

We pride ourselves in specially reserving the doctor's, hygienist's, and our qualified dental assistant's time, for each appointment. We make a point to not double-book our patients so that we can provide the best service in a timely manner to all of our patients. Therefore, a missed appointment negatively affects our health care quality, which in turn, can impact the level of care we are committed to providing to all of our valued patients.

Jamah Dental assesses a fee for missed appointments of $100.00 for every scheduled hour.

Sincerely,

Jamah Dental

I authorize Jamah Dental to charge me $100.00 missed appointment fee per hour in case I do not show up or cancel my appointment in less than 48 hours from the appointment time.

Patient/Guardian Signature: _____

Patient Name: _____

Date: _____

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Notice of Privacy Practices

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect nor copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to restrict your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your doctor is not required to agree to a restriction that you may request. If doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your doctor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice becomes effective on/or before May 23, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature or patient, parent or guardian:

_____ _____

Patient Name Date

_____ _____

Signature Relationship to patient (If Guardian)

5710 Cahalan Ave., Bldg. 8, Suite K, San Jose, CA 95123. Office (408) 578- 5911. Fax (408) 578-5935
www.MySiliconValleySmile.com

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OFFICE POLICY & INSURANCE BILLING AUTHORIZATION

As a condition of our treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

INSURED PATIENTS: We will be happy to process your insurance forms as a courtesy to you; however, we do require that you provide our office with all of the necessary insurance information at the time of your appointment.

PAYMENT ARRANGEMENTS: Payment is due at the time of treatment. We offer the following payment options, please circle one:

CASH CHECK CREDIT/DEBIT 3RD PARTY FINANCING

INSURANCE BENEFITS: Benefits depend solely on what the purchaser (employer) wishes to offer. Some plans cover as little as 15% or as much as 100% of covered services, with most falling in the 50-80% range. The insurance contract is between the patient and the insurance company. Your doctor is not required to agree to a restriction that you may request. If doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

DIRECT INSURANCE PAYMENT AUTHORIZATION: I hereby authorize and direct payment of the dental benefits, otherwise payable to me, directly to Dr Hani Jamah/Silicon Valley Dental Center.

"USUAL & CUSTOMARY:" Patients should be aware that some insurance companies will only pay claim percentages based on their evaluation of what is "usual and customary" and not on our fee schedule.

PRE-AUTHORIZATION: It is the patient's responsibility to inform us if they want to pre-authorize their treatment if their insurance company requires re-authorization of intended treatment. We will be glad to pre-authorize your treatment; however, the process could take 4-6 weeks.

ACCOUNT BALANCE: The account balance is due in full within 60 days of services rendered regardless of any previously paid co-payment and/or outstanding insurance claims. The patient is responsible for the financial portion the insurance does not pay. All adjustments will be done after insurance payment is received. We suggest you contact your insurance company if payment has not been made within 30 days from the date of service.

RETURNED CHECKS: A $50 fee will be charged for returned checks.

REFUND POLICY: Any deposit made will take 30 days to refund. In addition, a 30% processing & materials fee will be deducted from the total amount.

APPOINTMENTS: We recognize that things come up. If you must cancel or reschedule your appointment, we request the following:

- Please do so with more than 2 working days advance notice to avoid a $75 charge for general dentist appointment and more than 1 working week advance notice to avoid a $200 charge for specialist appointment.
- Three cancellations and/or rescheduling without proper notice may result in dismissal from our practice.

COPY OF XRAYS/RECORDS: There is a $50 charge for x-rays only and $75 for x-rays and patient records. Requests are processed within one working week of receipt of payment.

I have read this agreement and fully understand its content. I understand that I am responsible for all charges regardless of my insurance coverage.

Print Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

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