Junaluska Family Dentistry

HIPAA FORM

Name of Patient _____ Date of Birth_____

JUNALUSKA FAMILY DENTISTRY is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	***Check type of information that can be given to person/entity on the left in the same section.***
☐ Voice mail	☐ Appointment reminders ☐ Financial
☐ Other person(s) with permission to receive information about patient listed above (provide name & phone number)	☐ Appointment reminders ☐ Financial ☐ Treatment
☐ Email communication (Provide email address) _____ **For email communication to occur, please accept the disclosure below.*	☐ Appointment reminders ☐ Financial ☐ Treatment
☐ Text communication (provide phone number) _____ **For text communication to occur, please accept the disclosure below.*	☐ Appointment reminders ☐ OTHER_____

☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Emergency Contact

Name_____

Phone Number_____

Photo taken (Example: pre/post procedure)

☐ May be posted in office

☐ May be posted on website and/or social media page

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature of patient or personal representative_____ **Date**_____

Junaluska Family Dentistry
Office and Financial Policies

Please read carefully. Your signature is required prior to receiving treatment.

Office Policies:

Only the patient is permitted in the treatment room unless otherwise approved by the office.

While every effort is made to provide a thorough examination and accurate treatment recommendations, additional conditions may be discovered at subsequent visits as debris is removed or as further services are performed by the Doctor or Hygienist.

Our front desk staff is responsible for scheduling, billing, and account matters. Please direct all related questions to them to avoid interruptions to patient care.

Financial Policy:

If you require financing, please request information prior to scheduling or attending any treatment appointment.

A definite payment arrangement must be made before treatment is rendered.

Payment is due at the time services are provided and will be collected accordingly.

A **7-day grace period** is provided following the due date. **Balances over 60 days will be assessed a $5 late fee per month** until paid in full.

Broken Appointment Policy:

Patients may cancel or reschedule appointments with **24–48 hours' notice**.

Missed appointments (no shows) or canceled without the required notice may incur a **$50 non-refundable fee.**

Emergency situations are reviewed on a case-by-case basis, and fees may be waived at the discretion of the practice.

This policy applies to **all appointments, including your first visit**.

Consent and Privacy Acknowledgment:

I understand that I may revoke this consent at any time by notifying the practice **in writing**.

I understand that Junaluska Family Dentistry staff may use or disclose my personal health information for treatment, referrals, payment, quality assessment, and administrative operations. I may request restrictions on the use or disclosure of my information **in writing**; requests are considered on a case-by-case basis, but Dr. Osborne is not required to agree to requests for restrictions.

Patient/Responsible Party Signature: _____ **Date:** _____