TRUE
DENTAL

Patient's Name: _____ **Date of Birth:** _____

Office Policy Statement

Welcome to our office. It is a pleasure to serve your dental needs. Please note that your time is important to us. Procedures and appointments are scheduled in time blocks to fit your individual needs and we offer extended hours for unique situations.

- Please have your insurance information available for each visit, and inform us of any changes in your personal or medical data
- **Co-payments, deductibles, and incurred expenses will be collected *on DAY OF SERVICE***
- Bridges, crowns, partials, and implants must be paid in full upon insertion
- Bleaching and other cosmetic services are usually not covered by insurance and must be paid in full at time of service
- In order for you to maintain the best oral health, it is our policy that you meet the American Dental Association hygiene standards by having a dental cleaning *at least* once every six months and an annual checkup with x-rays. We will schedule your recall appointment before you leave the office

Cancellation Policy

We offer an automated courtesy call two days prior to your appointment. You are responsible to remember your appointment.

- Allow us a 24-hour notice of cancellation
- If you are more than 15 minutes late, you will be asked to reschedule your appointment
- Our appointment policy does allow for a limited number of failed appointments. **After three failed appointments (*no-show or a cancelled appointment without a 24-hour notice*), you will be dismissed from our office at our discretion**

By signing below, I certify that I have read and agree to abide by True Dental's Office Policy Statement and Cancellation Policy.

Signature: _____ **Date:** _____

Authorization for Insurance Submission

I certify that I, and/or my dependents, have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to True Dental all insurance benefits, **if any**, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dental facility may use my health care information and may disclose such information to the above-names insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

By signing below, I authorize True Dental to submit claims to my insurance, or charge the responsible party if no active dental insurance, on day-of-service.

Signature: _____ **Date:** _____

Relationship to insurance subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Please Complete Both Sides

Compliance Assurance Notification for Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability Act (HIPAA) and particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Patient Consent Form

The Department of Human and Health Services has established a "Privacy Rule" the help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to those we feel are in need of your health care information, and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse disclosure of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

We understand that you may have a spouse/parent/child that you would like to call or text on behalf of yourself, whether that be to confirm/reschedule appointments, make new appointments, update personal information on your account, etc.

_____ **I DO NOT** give TRUE Dental my permission to discuss my account, treatment, or any other PHI with anyone other than myself

_____ **I DO** give TRUE Dental my permission to discuss my account, treatment, or any other PHI with the following:

_____	_____	_____
Name	**Phone Number**	**Relationship**
_____	_____	_____
Name	**Phone Number**	**Relationship**

By signing below, I acknowledge that I have read and understand the above-information.

Signature: _____ **Date:** _____