Don M. Lunn, D.D.S.
FINANCIAL POLICY

Payment in full is expected when services are rendered.

Insured Patients

►Although your insurance may assist you with partial payment of your healthcare, the estimated, uncovered, portion is due the day services are rendered.

►As a courtesy to you, we will file your insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at that time. We will however, continue to work with you and your insurance company to expedite your reimbursement.

Payment may be made by the following methods:

Cash _____ Check _____ MasterCard/Visa/Discover _____

Information is available upon request, for interest free financing through the following third Party:

Care Credit

►I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.

►I authorize all insurance benefits paid directly to Dr. Don M. Lunn.

►If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Dr. Don M. Lunn or make payment immediately to Dr. Don M. Lunn.

►I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons (worker's comp, accident, etc.)

*►When being referred to a specialist, I am responsible for making sure that the doctor is on my insurance plan.

►A finance charge of 21% APR will begin to accrue after 90 days from the date of service on the unpaid balance of my account even though insurance may be pending.

►A fee of $29.00 will be incurred for each returned check.

►I agree to pay collection costs, attorney fees, court costs, and interest from the date of service if this account is assigned to collection status.

*►I authorize that I will be called at the numbers provided in regards to confirming appointments, account balances, and insurance information, and messages may be left on any answering service at such given numbers.

*►I understand that my appointment has been reserved solely for me. Should I fail to cancel my appointment without 24-hour business day notice, I agree to pay $61.00 for my appointment time.

►I have read, understand, and agree to the above terms.

_____ _____

Signature of Responsible Party Date

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The health insurance Portability & Accountability Act of 1966 (HIPAA) requires all health care records and other individually identifiable health information used of disclosed to us in any form, whether electronically, on paper, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activiites, and utilization review. For example, we disclose treatment information when billing a dental plan for dental services or to collection agency for collection of a debt owed.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family, friend or other personal representative to the extent necessary to help with your health or with payment for your healthcare. in addition, we may use your confidential information to remind you of appointments by sending reminder appointments postcards and/or leaving a message at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by resending a written request to our Privacy Office at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The rights to access inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- the right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care opertions.
- the right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practice will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practice, please contact:

Teresa Hayes
Don M. Lunn, D.D.S.
5802 Nolensville Road - Suite 101
Nashville, TN 37211
615-832-5899

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independent Avenue, S.W.
Washington, DC 20201
877-696-6775 (toll free)

Signature **Date**