CLEMONS COSMETIC and FAMILY DENTISTRY
EDWARD J. CLEMONS JR., DDS, P.A.
5011 SOUTHPARK DR STE 110 DURHAM, NORTH CAROLINA 27713
(919) 361-9700 Office (919) 361-9747 Fax drclemons@smilesbyclemons.com

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____ **Email address**: _____
The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

Comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:
☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:
☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:
☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
☐ It was emergency treatment
☐ I could not communicate with the patient
☐ The patient refused to sign
☐ The patient was unable to sign because
☐ Other (please describe) __

Signature of Privacy Officer _____ Date: _____

(OVER)

CLEMONS COSMETIC & FAMILY DENTISTRY

EDWARD J. CLEMONS JR., DDS, PA
5011 Southpark Dr., Suite 110
Durham, NC 27713
(919) 361-9700 Office / (919) 361-9747 Fax
Email: drclemons@smilesbyclemons.com
Website: smilesbyclemons.com

Appointment Policy and Guide to Patient Care

We take great pride in the quality of care that we deliver. One of our goals is to do everything possible to make your dental visit pleasant. If you have a dental insurance plan, do not hesitate to ask questions about your plan or any aspect of the treatment we are recommending. In effort to maintain this high-level of care, we have instituted office and insurance policies, along with appointment guidelines regarding cancellations/no-show/lateness. Compliance with this policy will allow patients to receive treatment in a timely and efficient manner, promoting optimal care and oral health.

- We will be happy to file your insurance as a courtesy to you. Be aware that insurance is a contract between you, your employer, and the insurance company. We will gladly help you obtain your maximum insurance benefits. However, you will be responsible for your account balance regardless of what your insurance pays.
- Once appointments are scheduled, patients are expected to attend each and every session at the appointed time.
- If you are going to be more than 15minutes late for scheduled appointment, please call to let us know so that we may notify our dental team.
- All cancellations must be communicated to the office 48 'working' hours in advance of your appointment**. As of Jan 1, 2017, there will be a $75 charge for a broken appointment, if two business days notice is not given.** This charge must be paid prior to any future appointments. After two broken appointments without proper notice, we may ask you to select another dental provider. Receiving reminder calls, texts, e-mails to remind you of your appointment is provided as a courtesy. You are ultimately responsible for remembering your scheduled appointment.

Please know that your estimated payment will be due at the time the service is rendered. Accepted methods of payment are cash, personal check, credit or debit cards (Visa, MasterCard, American Express, or Discover) and Care Credit. As of Jan 1, 2017, if your account becomes past due over 60 days, there will be a late fee of $5.00 per month added to your account. As of Sept 1, 2016, accounts turned over to a collection agency will incur all fees charged by the agency for account collections, not to exceed 16% of the amount in past due amount.

We appreciate your understanding and cooperation with this policy.

I have read, understand, and agree to abide by the aforementioned policy.

I acknowledge that I was provided with a copy of the Clemons Cosmetic & Family Dentistry to Appointment Policy and Guide to Patient Care.

Patient Signature: _____ Date: _____

(OVER)

CLEMONS COSMETIC & FAMILY DENTISTRY

EDWARD J. CLEMONS JR., DDS, PA
5011 Southpark Dr., Suite 110
Durham, NC 27713
(919) 361-9700 Office / (919) 361-9747 Fax
Email: drclemons@smilesbyclemons.com
Website: smilesbyclemons.com

To accept insurance payments, we now require that a credit/debit card be left on file with our office.

I authorize Dr. Clemons and Clemons Cosmetic & Family Dentistry to keep my signature on file and to charge my credit card account for the balance of charges not paid by my insurance carrier, and not to exceed $50.00. We will call on all balances over $50 for authorization before charging your credit card. ***

Any overpayment on the account will be refunded to the same credit card used for payment.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to Dr. Clemons and Clemons Cosmetic & Family Dentistry and provide alternative payment for the committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient's Name: _____

Cardholder Name: _____

Type of Card: __Visa __MasterCard __American Express __Discover __Care Credit

Account Number: _____ **Expiration Date: ___/_____**

Card CVV _____ Billing Zip Code _____

Cardholder's Signature: _____ **Date: ___/__/_____**

Witness Signature: _____ **Date: ___/___/_____**

***If your balance exceeds $50.00 and no payment attempts have been made, this agreement authorizes the office of Edward J. Clemons Jr., DDS to charge the above account for the full balance after 60 days of non-payment.