Haddad Dental
Family and Cosmetic Dentistry
7201 Wisconsin Avenue. Ste 370
Bethesda, MD 20814
301-664-6447

PATIENT PRIVACY FORM

Patient Information:

Name:_____ **SSN#** _____ **DOB**_____

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED. IN ADDITION, IT DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

Bethesda General Dentistry and Cosmetics is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT
We may disclosure your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT
We may disclose your health information to your insurance for the purpose of payment or health care operations.

WORKERS' COMPENSATION
We may disclose your health information as necessary to comply with Maryland State Workers' Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying as family member, or another person responsible for your care about your medical conditions or in the event of an emergency or your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling diseases, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the food and drug administration problems with products and reactions to medications, reporting disease or infections exposure.

LAW INFORCEMENT
We may disclose your health information to a law enforcement official for purposes such as identifying or locating suspect, fugitive, material witness or missing person, complying with court order or subpoena, and other law enforcement purposes.

_____

Patient Signature or Guardian Date

Haddad Dental
Family and Cosmetic Dentistry
7201 Wisconsin Avenue. Ste 370
Bethesda, MD 20814
301-664-6447

Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Check
3. MasterCard
4. Visa
5. Credit card authorization for recurring charges:
    a. Treatment exceeds $200
    b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children and financially legal guardians of other adult patients are financially responsible for payment.

18% annual **interest** is charged for any unpaid balance. A $15 fee is charged for nonpayment.

There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there will be a **$75 FEE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE**.

I, _____ , agree to these financial terms.

_____

Patient Signature or Guardian Date