Monica Puentes, D.D.S.

HIPAA CONSENT FORM, OFFICE APPOINTMENT, OFFICE FINANCIAL POLICIES AND RECORDS RELEASE

Your signature acknowledges your understanding and acceptance of the following:

- **48 Hour Cancellation Policy -** In order to avoid a missed appointment cancellation fee of $25, please provide us with 48 hours advanced notice. This will allow us to fill the doctor's schedule.
- **Co-payment due when services are rendered** – All known or estimated co-payments are due when services are rendered. We will provide you with an estimate of your co-payments prior to or during your visit.
- **Late fees and interest charges** – As a courtesy our office will process insurance claims for you if we are contracted with your insurance provider. Any claims outstanding after 90 days will become patients' responsibility and full balance is due to the office. All balances older than 90 days will incur $20 late fee. Any unpaid balances after 120 days will be submitted to the Collection Agency.
- **Refunds – No refunds** will be issued under any circumstance, we will gladly give you credit to be used on dental treatment only. All treatment that was paid with our financing company will be charged a processing fee for any amount that has to be credited.
- **Insurance and contact information** – You are responsible for updating our office with any changes to your insurance coverage and or personal information including work performed at other offices, phone numbers, address, job changes, etc.
- **Co-pay write-off** – Per our contract with your insurance company we cannot write-off your co-payments. Please discuss any finance concerns with our team. We offer many different payment plans to fit your needs.

Your signature acknowledges receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment, and Operations.

By signing below, I hereby acknowledge that I have been provided with a copy (take-home by request) of this office's Notice of Privacy Policies Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information of treatment purposes, payment activities and healthcare operations of the office as described in the notice.

Your signature acknowledges your granting medical records release permission.

By signing below I grant Dr. Monica Puentes Dental Office permission to transfer my x-rays and medical treatment summary to licensed medical professionals for purpose of my dental/medical treatment now and in the future at my request or per Dr. Monica Puentes referral (to specialist, or other doctors, etc).

_____ _____

Signature-Patient/Legal Guardian Date

_____

Print Name and relationship to patient

11116 Rives Avenue, Downey, California. 90241 **(562) 861-3181**