STEVE EDWARDS, D.D.S. ● ROBERTO VILLARREAL, D.D.S. ●CRAIG LONG, D.D.S.
●AIMEE GARCIA, D.D.S. ● LAUREN MALITZ, D.D.S

16131 Nacogdoches Rd ● San Antonio, TX 78247
(210) 655-2753 Ph. ● (210) 655-3443 Fax

ada@advanceddentalsa.com
www.advanceddentalsa.com

FINANCIAL POLICIES

Please let us welcome you to our practice. We are looking forward to providing you with the best dental care available and serving all your dental needs. Feel free to inquire about any service that you may need.

- **As a courtesy, we will file your dental insurance and take assignment of benefits. Your portion will be due at the time services are rendered. If the insurance payment is less than what we estimated, then you will be responsible for the difference.**
- ***IF YOU NEED TO CANCEL AN APPOINTMENT, PLEASE NOTIFY US 24 HOURS IN ADVANCE.*** **IF WE ARE NOT NOTIFIED (24 HOURS PRIOR TO YOUR APPOINTMENT),** ***A CANCELLATION FEE OF $75 WILL BE APPLIED TO YOUR ACCOUNT.***
- **If financial arrangements need to be made, please speak with administrative personnel BEFORE TREATMENT BEGINS.**
- ***ALL PAYMENTS FOR SEDATION APPOINTMENTS ARE DUE BEFORE TREATMENT BEGINS***
- **There will be a $35 fee applied to the account for returned checks. Payment must then be made by cash or credit card only. Non-payment will result in further collective actions.**

Again, we thank you for choosing to become a part of our dental family!

I agree to the above guidelines and agree to the assignment of insurance benefits to Steve M. Edwards, DDS

Signature of responsible party: ________________________________ Date: ____________

Patient HIPAA Compliance Consent Form

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 the doctor and all staff members continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule".

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

We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. 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. None of your private information will be released to anyone but you without your expressed written consent.

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 a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also want you to know that we support your full access to your personal dental records. Other business that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations or payment. 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. Should you refuse to disclose your personal health information to us, we have the right to refuse to treat you under this law. Should you disclose your information to us, but refuse to allow us to disclose it to your insurance company; you will be responsible for the full balance on your account at the time of service, instead of the customary 30 day grace period that we allow for 3rd parties to pay.

I, ______________________________________ DO hereby consent for Steve M. Edwards, D.D.S, to release the minimum amount of my personal health information necessary for treatment, health care operations or payment to any necessary entity, business or person. I understand that no information will be released that is not absolutely necessary to the situation.

I, ______________________________________ DO NOT consent for any of my personal health information to be released by Steve M. Edwards, D.D.S., to any entity, business, or person other than myself, unless I specifically, in writing, authorize this release of information each and every time it is needed. I understand that this decision means that I am responsible for all balances on my account at the time of service, and that I am responsible for filing my own insurance claims for reimbursement.

Print Name:____

Signature: _______________________________ **Date:** ________________