2869 Wilshire Dr. · Suite #101· Orlando, FL · 32835
Telephone: (407) 291-7220 Fax: (407) 291-7221
Website: www.mymetrosmiles.com Manoj K. Patel, D.D.S

Patient Responsibility and Inform Consent

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of the patient's dental/medical needs, and also for Metro Smiles to use as an example. I understand that it is my responsibility to advise your office of any changes in the information obtained in this form. I authorize the use of my social security number to file my dental claim.

2. Metro Smiles is proud to offer expert assistance in maximizing your insurance benefits and filing your claims. We work with many insurance companies and will verify your insurance plan with our selected list of quality dental and/or medical insurance programs. Our insurance department will provide as much information of your policy as possible. However, payment for services is always the responsibility of the policy holder. **I hereby authorize and direct my insurance carrier(s) to issue payment checks directly to the office of: Manoj K. Patel, D.D.S. any benefits due under my insurance plan.** I understand this also authorizes my physician to release to my insurance company any dental/medical information necessary to process my claim(s).

3. I agree to pay any portion of the fees not covered by my dental and/or medical insurance company for **ANY r**eason. **I understand that any prior balance or co-pays due will be collected prior to services being rendered.** . I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, fees due at the time services are rendered unless other arrangements have been made. **In the event payments are not received by the agreed upon dates, I understand that collections may proceed after 90 days.**

4. I understand that Metro Smiles can only **ESTIMATE** the approximate percentage or amount that my insurance company will pay. I understand that my balance remaining on my account after 30 days due to nonpayment based on the quality of care for patients, not the standard set by any insurance company.

5. **I understand that it is my responsibility to know the plan guideline in reference to cleanings, fluorides, and exams for my family members and myself.** I understand that Metro Smiles will recommend treatment based on the quality of care for patients, not the standard set by any insurance company.

6. Fees quoted are in effect for **90 days** and are subject if the treatment does not begin within 90 days.

7. I understand that if treatment is started and not completed and Metro Smiles incurs lab fees, the office has the right to adjust the balance on my account and charge for temporary services (including doctor time and lab fees). I understand that if I do not complete treatment as recommended the previous adjustments will apply. Any monies rendered will be retained to cover these fees.

8. I understand that Metro Smiles will keep and apply any monies I have paid towards the treatment started. Treatment not completed within 90 days of the start date (unless otherwise specified) will be considered incomplete treatment and the previous mention adjustments will apply. Treatment resumed at a later date will be charged a fee at my scheduled appointment or when billed by Metro Smiles.

9. **I understand that Metro Smiles has a 48-hour cancellation policy and will charge a fee ($25 for every 30 minute(s)) for appointments that are cancelled with less than 48 hours or the same day, unless deemed excused/courtesy or an uncontrollable circumstance or emergency.** I understand that I will be responsible to pay these fees at my next scheduled appointment or when billed by Metro Smiles.

10. I understand that Metro Smiles will be happy to duplicate, and make available to me at my request, any x-rays that have been taken for the purpose of diagnosis. **I acknowledge that Metro Smiles will need a minimum of 48 hours' notice for any duplicate request.** I understand that Metro Smiles will keep the original x-rays on file and I will receive a duplicate of the x-rays. **I agree to pay the minimum duplication fee of $20.00 for these x-rays and sign a record release form as required by law to have a paper or e-mail copy given to me.**

Signature_____

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Manoj K. Patel, D.D.S.

HIPPA Consent Form

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will we usually will not ask you for special written permission.

We will ask for special written permission in the following situations:

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

1. When a state or federal law mandates that certain health information be reported for a specific purpose.
2. For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
3. Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
4. Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
5. Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
6. Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
7. Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
8. Uses or disclosures for health related research;
9. Uses and disclosures to prevent a serious threat to health or safety;
10. Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the Foreign Service.
11. Disclosures of de-identified information.
12. Disclosures relating to worker's compensation programs.
13. Disclosures of a "limited data set" for research, public health, or health care operations.
14. Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
15. Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
16. I specify other uses and disclosures affected by state law.

APPOINTMENT REMINDERS

Unless you tell us otherwise, we may call, text, e-mail or write to remind you of scheduled appointments, or that it is time to make a routine appointment, and/or if you still have pending dental treatment needed, as well as financial statements and monies due. We may also leave you a reminder message of your upcoming dental appointment on your home or cellphone voicemail or with someone who answers your phone if you are not available.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

1. Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
2. Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
3. Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
4. Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
5. Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
6. Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

******If you want more information about our privacy practices, call or visit the office in person at the address or phone number shown at the beginning of this Notice.

******At any time you may choose to share your information with whomever you choose by signing our consent for "Authorization Records Release" form. This will entitle our office to release our records to you, or whomever you allow.

I acknowledge that I have read Manoj K. Patel, D.D.S. (with Metro Smiles) Notice of Privacy Practices.

Signature _____