ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

Patient or Personal Representative

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Mark J. Gasbara D.D.S.

Telephone: 410-551-4600_____Fax:410-674-5551_____

Address: 1215 Annapolis Road, Suite 208, Odenton, MD 21113

14 W. Valerio St., Suite C
Santa Barbara, CA 93101

INSURANCE BILLING SERVICE

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

For Patients WITH Insurance

Your portion of the payment for services not covered by your insurance coverage is due at the time of service or in full within 30 days after insurance has paid if there is a balance.

It should be mentioned that your insurance coverage is an agreement between YOU and YOUR INSURER. As a courtesy, we will bill primary and secondary insurance (but not tertiary insurance) for you, however, in the event that your insurance company categorizes services rendered as "non covered" or "not medically necessary", **you are responsible for payment in full.**

Each month you will receive a statement for any charges which are your responsibility. These amounts are **due and payable within 30 days.**

For Patients WITHOUT Insurance

Payment is due at the time of service and may be made by cash, debit, credit card, or check.

I _____, have read and agree to the terms of Heath Montgomery, DMD service policy.

_____ _____

Signature of the Patient /Responsible party **Date**

INFORMED CONSENT FOR SERVICES

I give consent for the Dentist(s) at Heath Montgomery, D.M.D. to treat my dental needs. I understand that treatment recommended to me is only an estimate, and may change in the process of treatment.

I authorize the Dentist to choose the dental material that best suits my dental needs. I also understand that **I may ask questions** about the dental materials used in my treatment.

I authorize the Dentist to choose the anesthesia that best suits my dental needs. I understand that **I may ask questions** about the anesthetic used in my treatment. I also understand that there are risks associated with the administration of anesthetic. Some of the risks include, prolonged, temporary, and on very rare occasion permanent, loss of feeling in the area where the anesthetic is administered. Also, prolonged trismus (sore muscle) around the area of administration may occur once the anesthetic has worn off.

I understand there is a **48 hour cancellation policy**. If I cancel less than 48hrs prior to my dental appointment, or do not show up, there will be a $65.00 Failure to Show Fee added to my account for every hour or part there of that is missed. (i.e. 1.5 hr appointment is $130).

I have read the above policies and conditions. I consent to treatment in this office for myself, and anyone for whom I am legally responsible.

_____ _____

Signature of the Patient /Responsible party **Date**