Financial Policy

We are pleased to have an opportunity to provide you with the highest quality dentistry possible, in an open, honest and pleasant environment and to keep you informed of treatment recommendations and financial obligations. If you have dental insurance, we will be glad to help you receive your maximum allowed benefits.

The following is our office payment policy:

• Payment is due at time services are rendered. We offer several flexible options including cash, credit cards , as well as no-to-low interest payment plans upon credit approval.

• If you are a patient with dental insurance, it is important to remember that your insurance plan is a contract between you, your employer and the insurance company. This contract is in no way a binding obligation between the dental insurance company and Davidson Dental Group. Although we will always use best efforts to work with your insurance provider, in certain instances we have no control over their payouts, which is why if we have not received payments from your insurance company within 60 days of the date of service, the balance becomes your responsibility. For this reason, you should be fully aware of the provisions, as we always provide the best estimate, but it is not a guarantee of payment.

• You will always receive a treatment plan for services, which estimates your portion of payment. If we estimate and collect your co-payment and the insurance underpays or denies a benefit, you are responsible for the remaining balance.

• Not all services are covered by insurance. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium/contract.

• To help us process your insurance claim for your reimbursement, please keep our office aware of any changes to your plan. Also, please call your insurance carrier to expedite claims if a claim is not paid within thirty (30) days.

• Patients with an outstanding balance must make arrangements for payments prior to scheduling future appointments.

Collection Fee - *(These fees cannot be charged to your insurance)* I understand and agree that all services rendered by me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Unpaid balance statements are sent monthly, and are due upon receipt. Interest will accrue and compound monthly at 1.5% on any unpaid balance and, in case any unpaid balance remains after 90 days, your account will be assigned to a collection agency and/or reported to a credit reporting agency, along with an assessed 30% collections fee. If during the admission or application process I have provided a cell phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account should it become delinquent.

Returned Check Fee - A $35.00 fee applied to any returned check. We hope by presenting our policies to you in the beginning, we will avoid any misunderstandings and have more time to dedicate to your dental care. If you have any questions regarding the above information, please do not hesitate to ask. We are here to help you!

X-Ray Request Fee - We will gladly provide you a hard copy of your x-rays and/or intra-oral photos for a fee of $25.00 upon written request.

Cancellation Policy - Our office is committed to providing quality care to all of our patients, and to do so, we must value your time, as well as ours. We understand and respect that on occasion other circumstances in our lives may arise and take precedence. Our intention is to not penalize patients, but rather to ensure that we have a system in place to properly value your time as well as our staff's time. If you need to make any changes, or to cancel your scheduled appointment, we ask that you call or email our office at least two (2) business days prior. If you fail to provide the required notice, we reserve the right to charge your account a minimum $150.00 fee, and a maximum $750.00 fee. The exact amount will depend upon the nature of your appointment and based upon 25.00% of the cost of your scheduled appointment.

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I have read and agree to the above provisions, as well as the attached credit card policy. Any mention of “you” or ‘your” refers to me, the undersigned patient.

Patient Name:_____

Patient's Signature:_____**Date:**_____/_____/_____

Credit/Debit Card Policy

If you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a copy of your credit card at the time you check in, and the information will be held securely within our network (and never outside our network). We will only charge your card for outstanding balances, in accordance with the above and below mentioned financial policies.

If, after a claim has been submitted to your insurance carrier: (1) the claim is denied; OR, (2) the charges are not paid (or only partially paid) by your insurance carrier within 60 days of the date of service; Davidson Dental Group has permission to charge your credit or debit card for the entire amount owed for treatment and/or services provided to you or your dependent. You understand that in the event your credit or debit card has been charged for medical treatment or services, and then your insurance carrier subsequently makes payment to Davidson Dental Group for those charges, this office will issue a credit to your account, or provide a reimbursement payment to you. If payment is denied by your credit or debit card company, you will pay the entire amount within 30 (thirty) days.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (1) your dental plan requires prior authorization before receiving services at Davidson Dental Group, and such authorization was not obtained; (2) you receive services in excess of allowable charges; (3) your dental plan determines that the services you received at Davidson Dental Group are not medically necessary and/or not covered by your insurance plan; (iv) your dental plan coverage has lapsed or expired at the time you receive services at Davidson Dental Group. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

This authorization shall remain effective unless expressly revoked by you in writing, delivered to the offices Davidson Dental Group. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays due at the time of the visit will, of course, still be due at the time of the visit. Should you decline to keep your credit card on file, pre-payment in full (total fee including any estimated insurance) will be required for all services at the time of booking.

If you have any questions about this payment method, do not hesitate to ask.

Visa:_____ **MasterCard:**_____ **Discover:**_____

Patient's Name:_____**Cardholder's Name:**_____

Cardholder's
Billing Address:_____**City:**_____**State:**_____**Zip:**_____

Credit /Debit Card Number:_____**Expiration Date: Month**_____ **Year**_____

CVV (3-digit code):_____

Cardholder's Signature:_____

Date:_____/_____/_____

Dental Patient Survey

(When answering each question, be as detailed as possible.)

1. What dental problems cause you the most trouble?

2. What would you most want to achieve from dental care?

3. How would you describe the perfect Dentist? Please be specific.

4. What key factors most influence you when choosing a Dentist?

5. What would be the most convenient days for you to visit a Dentist?

6. What would be the most convenient hours?

Notice of Privacy Practices

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.

I. Dental Practice Covered by this Notice This notice ("Notice") describes the privacy practices of Elena Davidson, DDS, PC (doing business as Davidson Dental Group, and hereinafter referred to as "Dental Practice"), as per the requirements of the HIPAA1 Privacy Rule2 ("HIPAA") and with respect to Protected Health Information3 ("PHI"). "We" and "Our" means the Dental Practice. "You" and "Your" means Our patient. (Your "Authorization").

II. How to Contact Us/Our Privacy Official If You have any questions or would like further information about this Notice, You can contact the Dental Practice at:

Davidson Dental Group
ATTN: Elena Davidson
443 Joaquin Ave. #A
San Leandro, CA 94577
(510) 352-9212
drelena@davidsondentalgroup.com

III. Our Promise to You and Our Legal Obligations The privacy of Your health information is important to us. We understand that Your health information is personal and We are committed to protecting it. This Notice describes how We may use and disclose Your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes Your rights to access and control Your protected health information. Protected health information is information about You, including demographic information, that may identify You and that relates to Your past, present or future physical or mental health or condition and related health care services. We are required by law to:

• Maintain the privacy of Your protected health information;
• Give You this Notice of Our legal duties and privacy practices with respect to that information; and
• Abide by the terms of Our Notice that is currently in effect.

IV. Last Revision Date This Notice was last revised on March 1, 2019.

V. How We May Use or Disclose Your Health Information The following examples describe different ways We may use or disclose Your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose Your health information for the following purposes:

1. "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.
2. The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.
3. "Protected Health Information" is information (i) about Your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies You directly or indirectly (i.e., there is a reasonable basis to believe that the information could be used to identify You); and (iii) that is maintained or transmitted by the Dental Practice.

A. Common Uses and Disclosures
1. Treatment. We may use Your health information to provide You with dental treatment or services, such as cleaning or examining Your teeth or performing dental procedures. We may disclose health information about You to dental specialists, physicians, or other health care professionals involved in Your care.

2. Payment. We may use and disclose Your health information to obtain payment from health plans and insurers for the care that We provide to You.

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3. Health Care Operations. We may use and disclose health information about You in connection with health care operations necessary to run Our practice, including review of Our treatment and services, training, evaluating the performance of Our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development. Any audio or video recordings made for this purpose will not be part of Your medical record.

4. Appointment Reminders. We may use or disclose Your health information when contacting You to remind You of a dental appointment. We may contact You by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose Your health information to tell You about treatment options or alternatives or health-related benefits and services that may be of interest to You.

6. Disclosure to Family Members and Friends. We may disclose Your health information to a family member or friend who is involved with Your care or payment for Your care if You do not object or, if You are not present, We believe it is in Your best interest to do so.

7. Disclosure to Business Associates. We may disclose Your protected health information to Our third- party service providers (called, “business associates”) that perform functions on Our behalf or provide us with services if the information is necessary for such functions or services. For example, We may use a business associate to assist us in maintaining Our practice management software. All of Our business associates are obligated, under contract with us, to protect the privacy of Your information and are not allowed to use or disclose any information other than as specified in Our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent We are required by law to do so. For example, We are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine Our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom We believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

A. 5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court.

6. Law Enforcement Purposes. We may disclose Your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose Your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties. 8. Organ, Eye and Tissue Donation. We may use or disclose Your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose Your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

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10. Serious Threat to Health or Safety. We may use or disclose Your health information if We believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose Your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose Your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

13. 3rd Party Communications Initiated by You. We are always pleased when patients are willing to communicate their experiences received at the Dental Practice. Sharing Your story can help others who are interested in knowing more about the patient services provided by the Dental Practice, and can help promote Our mission of service. In the event You communicate with any 3rd parties (such as but, not limited to, social and/or review platforms) about Your experience with the Dental Practice, You then hereby grant permission to the Dental Practice to use, disclose, respond, comment or otherwise communicate on or to such 3rd party with respect to your personal health information.

14. Education and Promotion. You grant the Dental Practice the right to use, without limitation or any financial remuneration, Your intra-oral images, facial photographs and any testimonial(s) (in whatever form provided, such as text, video or audio) in any educational, marketing, or advertising materials, including use on the Dental Practice's web site. Your full name or personal contact details will never be distributed, and You may opt-out of this consent at any time by notifying the Dental Practice in writing. You also understand that if Your image is posted on the Dental Practice's web site, the image can be downloaded by any computer user, which is beyond the control of the Dental Practice, and You will hold the Dental Practice harmless from any such use or download.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information Uses and disclosures of Your protected health information that involve other uses or disclosures not described in this Notice will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, We intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information You have the following rights with respect to certain health information that We have about You (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, You must submit a written request to Our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review. You may request to access and review a copy of Your health information. We may deny Your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of Your health information in a format You request if it is readily producible. If not readily producible, We will provide it in a hard copy format or other format that is mutually agreeable. If Your health information is included in an Electronic Health Record, You have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity You designate in an electronic format. We may charge a reasonable fee to cover Our cost to provide You with copies of Your health information.

B. Right to Amend. If You believe that Your health information is incorrect or incomplete, You may request that We amend it. We may deny Your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with Your health information that You believe is incorrect or incomplete.

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C. Right to Restrict Use and Disclosure. You may request that We restrict uses of Your health information to carry out treatment, payment, or health care operations or to Your family member or friend involved in Your care or the payment for Your care. We may not (and are not required to) agree to Your requested restrictions, with one exception: If You pay out of Your pocket in full for a service You receive from us and You request that We not submit the claim for this service to Your health insurer or health plan for reimbursement, We must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and You indicate that communication by regular means could endanger You. When You submit a written request to the Privacy Official listed on the first page of this Notice, You need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of Your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting We provide in any 12-month period will be without charge to You. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify You in advance of this fee and You may choose to modify or withdraw Your request at that time.

F. Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give You a paper copy of the Notice at any time (even if You have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach. We are required by law to notify You if the privacy or security of Your health information has been breached. The notification will occur by email or first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of Your health information. The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps You should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what We are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If Your treatment involves this information, You may contact Our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice. We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information We have about You or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, Our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on Our website (if applicable) and in Our office and will provide a copy of it to You on request. The effective date of this Notice is March 1, 2019.

X. How to Make Privacy Complaints. If You have any complaints about Your privacy rights or how Your health information has been used or disclosed, You may file a complaint with us by contacting Our Privacy Official listed on the first page of this Notice. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against You in any way if You choose to file a complaint.

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ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE

You acknowledge that you have read and agree to the privacy practices and otherwise terms as described within the HIPAA Notice (“Terms”), dated December 14, 2018. Further, You authorize the Dental Practice to disclose Your PHI, pursuant to such Terms, or as required and/or permitted by law. This authorization shall expire two (2) years from the date that You terminate services with the Dental Practice (“Expiration Date”).

In order to determine the Expiration Date, the Dental Practice must be on notice with regard to Your termination of services, which may be accomplished by Your written communication to the Dental Practice, indicating an intention to terminate services and/or transfer Your dental records to another provider. It is completely Your decision whether or not to sign this Authorization.

We cannot refuse to treat You if You choose not to sign. If You sign this Authorization, You can revoke it prior to the Expiration Date above by sending written notice to the Dental Practice to the physical or email address indicated on the first page of this Notice. The revocation will not have any effect, however, on actions taken in reliance on this authorization prior to your revocation.

_____

Patient Name

_____

Patient Signature

_____/_____/_____

Date

OR

_____

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Other:**_____