BUTTONWOOD DENTAL
RAZVAN D. JORDACHE, D.M.D.
1212 Kempton Street
New Bedford, MA 02740-1589
Tel: (508) 999-2727

FINANCIAL POLICY

In our continued commitment to provide the highest quality dental care, we are pleased to offer you the following payment choices:

CASH OR CHECK
CREDIT CARD (VISA / MASTERCARD / DISCOVER)
CARECREDIT OR LENDING CLUB
PREPAYMENT**

***We are happy to offer a 5% courtesy adjustment for cash or check (3% credit card) for services over $1,000.00 when prepaid in full upon scheduling your appointment.*

Payment is due at the time of service regardless of whether or not your insurance benefits have been received, this includes procedures that are not covered by your insurance company. If unpaid, 1.5% interest will be charged per month and 18% per year on accounts 60 days after the treatment date. We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. As a courtesy, we will process your insurance claims and be happy to help you with any questions you may have regarding your insurance benefits-- but please note that your insurance policy is a contract between you and your insurance company.

Appointment times are reserved especially for you. If you miss an appointment or cancel without at least two business days notice, you may be charged a fee of $50. If for any reason you should need to change your appointment, there will be no charge provided you give us 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

I hereby agree acknowledge that I have read, understand and agree to the terms of this document relating to insurance coverage, payment for services, and the cancellation policy.

_____
Patient Name (Print)

_____
Signature (Responsible Party) Date

NOTICE OF PRIVACY PRACTICES
(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires That all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or oral, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes; treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to the insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other-uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with the respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, Including those related to disclosures to family members, other relatives, close personal friends, or Any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend tour protected health information

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

BUTTONWOOD DENTAL
NOTIFICATION OF PRIVACY PRACTICES AND
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, direct my treatment, and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that it may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or
disclosed to carryout treatment, payment or healthcare operations. I also understand you are not
required to agree to my requested restrictions, but if you do agree then you are bound to abide by
such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Buttonwood Dental
Razvan Jordache, DMD
1212 Kempton St New Bedford, MA 02740
www.Buttonwood-Dental.com

How did you hear about our office?

What is the most convenient way to contact you? (Call/Text/E-Mail)

What time/ days are you available to schedule appointments?

What are your primary dental concerns and/or goals?

Have you ever been advised to take antibiotics before having dental work?

(If yes, why?)

Do you use a CPAP machine or have sleep apnea?