

NOTICE OF PRIVACY PRACTICE  
ACKNOWLEDGEMENT

Beautiful Smiles Dentistry  
Patrick H. Im, D.D.S.  
1202 Cleo Way  
Dalton, GA 30720

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

Conduct, plan, and direct 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 certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above 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 carry out treatment, payment or health care operations. I also understand that you are not required to agree with my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

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## Financial and Insurance Policy

Payment is expected at the time services are received. In order to keep fees at a minimum, we have kept payment flexible by allowing the following methods of payment: Cash, check, MasterCard, Visa, Discover, American Express, or you may want to apply for dental financing through Care Credit. (Ask an Office Administrator for an application.)

Your insurance policy is a contract between you and your insurance company. This office does not guarantee or promise that your insurance will pay what they say they will pay. Usual and Customary fees vary from one insurance company to another and policies will change. Any services not covered, or coverage reductions made by your insurance will be your responsibility. We are not a party to that contract, however, we will be happy to file your insurance; and are willing to accept your insurance benefits as a partial payment. After 30 days, any insurance claim left unpaid, will be reassigned to your personal account for payment in full.

This office will not enter into any dispute with your insurance company. We will submit and re-submit claims but if coverage problems arise, payment is expected in full. We will do our best to assist you in dealing with your insurance company, adjuster, or agent to help remedy any dispute. If you receive a request of information from your insurance please answer promptly as this is delaying payment.

If you happen to receive a check from your insurance company and this office has accepted assignment, that would be an error on behalf of your insurance provider. Any check received in a case like this needs to be brought to this office immediately. We do receive notification when they issue checks and to where they are mailed.

If you change insurance companies or employer, you agree to inform this office promptly. Accompanying adults will be financially responsible for minors.

In the event that your account balance is not paid in full by said time, then the amount due could be turned over to a collections agency, at which time you would then become responsible for the collection agency fees. Should legal action become necessary to obtain monies owed Beautiful Smiles Dentistry, you will be responsible for any attorney fees and court cost incurred.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

## Personal Dental Evaluation

1. Is the appearance of your teeth pleasing to you? Yes or No. Give details.

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2. Are your teeth straight? Yes or No. If not explain

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3. Are your teeth crowded? Yes or No. If so, explain.

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4. Are you unhappy with any spaces in your teeth? Yes or No. If so, explain.

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5. Do you like your profile? Yes or No. If not explain.

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6. Do you frequently get headaches, facial pain or jaw joint pain? Yes or No. If yes, give details.

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7. Does your jaw click or pop? Yes or No. If yes, explain.

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8. If you could change anything about your teeth, what would it be?

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