SARA A. BENDER DDS, MS

Periodontics & Dental Implants
Diplomate of the American Board of Periodontology

CONSENT FOR LOCAL ANESTHESIA

I consent to the use of a local anesthetic. I understand that there is a slight element of risk involved with the use of a local anesthesia or the use of any drug. These risks may include but are not limited to: allergic reaction, bleeding, injury to blood vessels and nerves, and other unforeseen adverse effects.

I confirm that I have read and fully understand all of the information provided above.

_____ _____

Signature of Patient/Parent/Guardian: **Date:**

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Financial Policy

Our office is dedicated to providing superior care and service to you. Your complete understanding of your financial responsibilities is essential to your care and treatment. Please do not hesitate to discuss any questions or concerns you have about the following financial policy with us.

Your Insurance

Dr. Bender accepts payment at the time a procedure is completed. Our office will help file all insurance claims for you. Our office will allow partial payment for a service when an agreement has been reached regarding estimated dental insurance coverage. A pre-determination of benefit coverage is not always an accurate estimation of insurance coverage.

Upon request, Dr. Bender will send your treatment plan along with all supporting documentation and radiographs to your insurance carrier. With this information, your insurance carrier may determine coverage for a particular procedure. The process of obtaining a pre-determination takes approximately one month. The pre-determination is a written ***estimate*** detailing the expected payment by the insurance carrier for a procedure. Usually the pre-determination information is accurate; however, unprocessed claims or claims processed after a pre-determination has been created will alter insurance coverage.

Dr. Bender will accept payment for the ***estimated*** patient portion for a procedure and accept the remainder of the payment from the insurance carrier. ***ULTIMATELY, YOU ARE RESPONSIBLE FOR PAYMENT AND RECONCILIATION OF YOUR ACCOUNT. DR. BENDER IS NOT RESPONSIBLE FOR INACCURATE ESTIMATES MADE BY AN INSURANCE CARRIER.***

Appointment Policy

Time has been specifically reserved for your dental appointment. To protect the integrity of our schedule and to be fair to those on our waiting list, if you need to change your appointment, kindly give a 48 hour notice. For all **surgical appointments** we require one week notice. Failure to keep a scheduled appointment without proper notice may result in a minimum charge of $50.00. In the event of a cancelled/no-show appointment, we will require pre-payment for reserving you a new appointment. If you fail to honor a pre-paid appointment, the monies will apply to the forfeited appointment time. You will NOT receive a credit on your account for a failed pre-paid appointment. Finally, we may not be able to see you if you are more than **10** minutes late for an appointment

Payment

We accept cash, check and credit cards (Visa, Master Card, Discover Card, and American Express) and Care Credit for payment. There will be a $25 charge on all returned checks.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

(Signature of Patient or Responsible Party) (Date)

_____ (Printed name of Patient)

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _2___/__1__/__26__, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.
Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.
Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.
Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.
Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.
Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.
Required by Law. We may use or disclose your health information when we are required to do so by law.
Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security

activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.
Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Judicial and Administrative Proceedings . If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your

record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.
Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Sara Bender, DDS, MS
Telephone: (972) 668-6310 Fax: (972) 668-6311
Address: 3550 Parkwood Blvd. Suite 308, Frisco, TX 75034
E-mail: drbender@benderperiodontics.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. **You May Refuse to Sign This Acknowledgement**

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

Print Name: _____ **Sign**: _____

Date:_____

SIGNATURE ON FILE

I request that payment of authorized insurance benefits be made either to me or my balance to Dr. Sara A. Bender. I authorize any hold of medical information about me to be released in accordance with HIPAA regulations to determine benefits or the benefits payable to related services. I understand my signature authorizes the release of medical information necessary to pay the claim as well as requesting payment be made. If other health insurance is indicated in Item 9 of the ADA 1500 form or elsewhere on the approved claim forms, my signature authorizes releasing of information to the insurer or agency shown. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill and any remaining balances after insurance payment is received. I also understand that I have the right to revoke your authorization to use my health information, except to the extent that action has already been taken.

Print Name: _____ **Sign**: _____

Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

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:

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

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Date: _____

Patient Name: _____ Date of Birth: _____

The office will begin to contact you regarding appointments via e-mail and text message. Please fill out information below.

☐ Text message (number): _____

☐ Email (address): _____

- I agree that the dental practice may communicate with me electronically at the email and/or text cell phone number and address above.
- **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**
- I am responsible for providing the dental practice any updates to my email address.
- I can withdraw my consent to electronic communications by calling:
  The office of Sara A. Bender, DDS, MS, PA: (972) 668-6310.

OPT OUT:

☐ I wish to not receive e-mail or text messages (initial)_____

_____ _____

Signature Date