Emerald
DENTAL STUDIO

HIPAA Privacy Acknowledgement

The HIPAA notice states that you have a right to keep your medical/dental records private and that your healthcare providers cannot share your information with others without necessity on behalf of your treatment. This may include specialists and insurance carriers. Our office needs to make this statement available to you. The full HIPAA statement can be found in person at our front desk.

By signing, you are in agreement with this statement:
“I acknowledge that I have had the opportunity to read and acquire a copy of the ‘Karen Sierra D.D.S Notice of Privacy Practices’. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.”

Date:_____

Signature:_____

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Financial Policy Acknowledgement

Thank you for choosing us as your dental care provider. It is very important to us to provide you with the very best of care in a comfortable environment. We also strive to ensure that you clearly understand our financial policy and treatment needs. We will do our best to explain the fees associated with your needs as well as insurance benefits. For unaccompanied minors, we ask that financial arrangements be made prior to the day of their appointment.

Fees for services are due in full on the day of services. We accept cash, checks, Visa, Mastercard, Discover, American Express. We also offer extended payment plans options upon credit approval.

Insurance: We are happy to accept insurance coverage. We will verify your insurance on your behalf and determine your policy's estimated coverage for recommended treatment. Please understand that all insurance companies only tell us what they are estimated to pay. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. You are ultimately responsible for all fees generated by your treatment. The estimated patient copay and deductible for treatment rendered must be paid in full the day of service. You authorize Dr. Karen Sierra to release any necessary information requested by your insurance carrier and authorize payment directly to Dr. Karen Sierra for any benefits available under your insurance plan.

Check: There is a $30 service fee for any checks returned by the bank.

Cancellations: Please help us serve you and our patients with the best time management by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us 48 hours notice so that we may extend the courtesy of this time block for a patient on our waiting list. If you fail to provide a 48 hours notice more than once, you will only be able to reschedule your appointment on a day-of basis and will be charged a fee of $50.

By signing you are agreeing to the statement: "I have read and understand the office financial and cancellation policies".

Date:_____

Signature:_____