Amy Thompson DDS, PPLC
9633 Market Place, Suite 202
Lake Stevens, WA 98258
425-397-8888

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

I authorized the professional office to my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about metal health services) under the following terms and conditions:

1. Detailed description of the information to be released: **Information pertaining to the patient's treatment which will help in processing the claims only for our services; all healthcare information pertaining to the patient's dental records and obstructive sleep apnea.**

2. To whom may the information be released (name(s) of recipients): **Including patient's insurance company(s)** _____

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release: **Unless revoked earlier by the patient, this authorization shall expire either 1 year after the signature date, or upon discharge from services at New Life Dental Arts, whichever is later.**

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name _____

Source of Authority _____

NEW LIFE DENTAL ARTS FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.
To maintain the practice operations and prevent misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

Payment for our services is due at the time of service. If you are covered under dental insurance, all co-insurance and/or deductibles must be paid at the time of service. We accept cash, money orders, personal checks, Visa and Mastercard.

Insurance: As a courtesy, our office will file claims and deal with all insurance matters for you; however, your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
Our office strives to provide quality, dependable, and esthetic dental care. The "least expensive" insurance solution is seldom in the best interests of patient health. It is important to understand that insurance companies draw all contracts with the patient's employer. Their plan may not fit your overall dental health requirements. Any balance owed after insurance pays in your responsibility. If your insurance company has not paid your account in full within 60 days, the balance is then your responsibility. Secondary insurance is submitted after primary insurance payment has been received.

Returned Checks / Insufficient Funds: Checks or Credit Card payments that are returned as a result of insufficient funds/stopped or an account being closed will be assessed a $25.00 processing fee per RCW 62A.3 515.

Appointment Cancellation / Missed Appointment: This time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice to avoid a $75.00 cancellation fee per RCW 62A.3 520.

Late Payments: In the event your account becomes 90 days past due, we will assess a late charge equal to 12% per year; of the outstanding account balance or $1.00 whichever is higher per RCW 19.52.020(1). Failure to pay your account within 90 days will result in your account being turned over to a collection agency and reporting to the credit bureaus.

_____ _____

Signature of Patient or Legal Representative **Date**

Patients Name (please print)_____

Effective date of notice: January 21,2015

Notice of Privacy Practices

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425-397-8888

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.

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.

****Please ask if you would like to obtain a copy of the entire Notice of Privacy Practice.**

Acknowledgement of Receipt:

I acknowledge that I received a copy of New Life New Dental Arts Notice of Privacy Practices.

Patient Name: _____

Signature of Patient or Legal Representative: _____

Date: _____

PLEASE KEEP A COPY FOR YOUR RECORDS