OFFICE POLICY

Christine M Saad DDS PC
1202 S. Lapeer Rd.
Lake Orion, MI 48360

Important Dental Insurance Information for our Patients

To understand your insurance coverage can be quite challenging. We will assist you in any way possible to help you better understand your coverage. Unfortunately, there are restrictions on the information that your insurance company will disclose. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefits to our office.
2. Researching your dental insurance plan to advise you of benefits available to you.
3. Re-filing your insurance a second time, within 60 days.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY INCLUDE:

1. Payment of fees not covered by your insurance plan at the time the service is rendered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay for services rendered.
4. Keeping our office informed of any changes in your insurance coverage or employment prior to you appointment.
5. **GIVING US A 48 HOUR NOTICE IF YOU HAVE TO CANCEL YOUR APPOINTMENT. WE RESERVE THE RIGHT TO CHARGE A $50.00 CANCELLATION FEE WITHOUT A 48 HOUR NOTICE.**

Please sign below that you have read and fully understand the above policy.

I hereby authorize Dr. Saad to release any information to my insurance acquired in the course of my dental care, and to have benefits paid directly to Dr. Saad. I understand that I am responsible for any unpaid balances.

______________________________ ______________

Signature of Patient/Insured Date OVER-

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

______________________________ ___________________________

Patient Signature Patient Name (please print)

Date:__________________________

For office use only:

Patient refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

____

An emergency situation prevented the patient from signing the Acknowledgement.

________________________________ ______________________________

Office Personnel (signature) Office Personnel (print name)

Date:____________________________

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

___________________________________ _________________________________

Patient Signature Patient Name (please print)

Date:_______________________________