JohnWHITEDDS
Fellow of Academy of General Dentistry • Fellow of Academy of Dentistry International

Conditions of Treatment

Payment for Services

Payment for services rendered is expected at the time treatment is rendered. As a condition of treatment by this office, financial arrangements must be made in advance.

In consideration for the professional services rendered to me, the patient, by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fee necessary to collect funds.

A fee of $35 will be charged for all returned checks.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Sedation

For patients requiring sedation, we pre-order your medications prior to your appointment. We request payment of the sedation fee to reserve the necessary time and medications for you. Please note that if you are unable to keep your sedation appointment, all sedation fees charged are non-refundable.

For Patients with a Dental Insurance Plan

Patients with dental insurance plans must understand that all dental services are charged directly to your account and that you are personally responsible for payment of all dental services rendered. At the time of service, our office will estimate the amount that we expect to receive from your dental plan provider. Any remainder is due at the time of service. As a courtesy to you, our office will help prepare your plan's forms and assist in making collections from insurance companies and will credit any collections to your account. All claims not paid to us by your dental plan provider within 45 days of treatment will be due immediately, and billed to you. Any insurance amounts collected after this period will be returned to you as reimbursement.

Fee Estimates

As a patient, I understand that any fee estimates for dental care can only be extended for a period of three months from the date of examination.

Appointment Scheduling

We respect your time and your busy schedule. That's why we strive to stay on-time in our schedule throughout our day. We ask that you please arrive on-time so that we may complete your scheduled treatment. This will allow our office to stay on-schedule for our other patients.

Appointment Cancellation

We understand when emergencies arise that you may need to reschedule an appointment. If possible, we appreciate 2 business days notice for rescheduling your appointment for convenience. For appointments cancelled with less than 1 business day notice, your account will be charge a $50 fee.

☐ I acknowledge that I have read the above section title "Conditions of Treatment".

☐ I authorize the office of Dr. John White to take x-rays, study models, photographs or other diagnostic aids as deemed appropriate to make a thorough diagnosis of my dental needs.

☐ I understand that x-rays, study models, and photographs may be used by this practice, without use of my name, for the purposes of patient education, advertising or any other lawful purpose and I release and forever discharge Dr. John White from any claim, demands, or liability on account of such use or the quality of the reproduction of the materials provided.

☐ I acknowledge that I have received and reviewed a written copy of this practice's "Notice of Privacy Practices", that explains how health information may be used and disclosed and how I can get access to this information. I authorize the release of information under the "Notice of Privacy Practices".

Signature of patient, or parent, or guardian (responsible party): _____

Print Name: _____ Relationship to the patient: _____ Date:_____/_____/_____

NOTICE OF PRIVACY PRACTICES

For The Dental Practice of John I. White, DDS

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, and keep this form to refer to.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.20 for each page, to locate and copy your health information, and any additional postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed you health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer:	John I. White, DDS	**Address:**	7 Walden Ridge Drive, Suite 100 Asheville, NC 28803
Telephone:	(828) 684-3020	**Fax:**	(828) 684-5544