Perio Implant Center

WAHN KHANG D.M.D.
PERIODONTIST

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

*CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
*OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
*CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICAIN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE TO ABTAIN A CURRENT COPY OF THE NOTICE OF PRIVATE PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME:_____

SIGNATURE:_____

DATE:_____

FINANCIAL AGREEMENT

IF THIS ACCOUNT IS PLACED IN THE HANDS OF AN ATTORNEY FOR COLLECTION, I AGREE TO PAY ATTORNEY FEES OF THIRTY-THREE AND ONE-THIRD PERCENT OF THE UNPAID PRINCIPAL AND INTEREST IN THE AMOUNT ONE AND ONE-HALF PERCENT PER MONTH. BEGINNING 30 DAYS AFTER THE MONEY HAVE BECOME DUE OR EXPENSES HAVE BEEN INCURRED. I FURTHER AGREE TO PAY RETURNED CHECK CHARGES OF $20.00 PER RETURNED CHECK. **A $50.00 BROKEN APPOINTMENT FEE WILL BE APPLIED FOR ANY BROKEN APPOINTMENTS WITHOUT A 48 HOUR NOTICE.** ALSO IF ANY PORTION OF THE BILL IS NOT COVERED BY MY DENTAL INSURANCE, IT WILL BE MY RESPONSIBILITY.

PATIENT SIGNATURE:_____