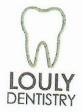
AMMAR C. LOULY, DDS-MSD

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

	NT GIVING CONSENT
Name:	
Address:	
Telephone:	E-mail:
Social Security N	umber:
	E PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Cons protected health	ent: By signing this form, you are consenting to allow Louly Dentistry/SNMI to use and disclose you information in order to carry out treatment, payment activities, and healthcare operations
this consent. Ou uses and disclos protected health	Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign representations and description of our treatment, payment activities, and healthcare operations, of the large we may make of your protected health information, and of other important matters about you information. A copy of our notice accompanies this consent. We encourage you to read it carefully and the signing this consent.
We reserve the operivacy practices apply to any of you	right to change our privacy practices as described in our Notice of Privacy Practices. If we change out we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may bur protected health information that we maintain.
	copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting
	Contact Person: Ammar Louly, DDS-MSD Telephone: (317) 869-0000 E-mail: Contacting Contac
	Address: 11530 East Washington Street Indianapolis, Indiana 46229
light to Revoke: ubmitted to the ve took in relianc reating you if you	You will have the right to revoke this Consent at any time by giving us written notice of your revocation contact person listed above. Please understand that revocation of this consent will not affect any action on this Consent before we received your revocation and that we may decline to treat you or to continue a revoke this Consent.
SIGNATURE SECT	ION
,	have had full a very transfer to
onsent form and onsent to use an perations.	your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my d disclose my protected health information to carry out treatment, payment activities, and health care
ignature	Date
	igned by a personal representative on behalf of the
ersonal Represer	ntatives Name
	tient

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.



INSURANCE/ FINANCIAL POLICY

Welcome to our practice! We appreciate the opportunity to provide you with the highest quality of dental care in a warm and caring environment. We've provided this letter to answer questions you may have regarding our financial policies.

Our office will gladly submit your insurance claims for services rendered. We will work hard to ensure that you receive the maximum dental insurance benefits entitled to you. We do ask that you pay any applicable co-pay or deductible at the time of service. Our office staff can provide you with your estimated balance. Please remember that your insurance is a contract between you and the insurance company, not your dentist and the insurance company.

Though we will estimate your insurance benefits as close as possible, it is only an estimate. An insurance claim is normally processed within 30-60 days. Should the claim go unprocessed we may ask you to intercede on your behalf. All treatment fees are the responsibility of the patient. Should insurance not pay in a timely manner, the patient is responsible for the fee in full. We will, of course, provide you with all the necessary forms and information needed to pursue your insurance reimbursement.

Payment Options:

Our office coordinator will explain your treatment fees, estimated patient balance, and discuss methods of payment: cash, checks, Visa, MasterCard, and Discover. We also offer an outside financial service as an alternative financial option.

Late Charges:

A 1.5% late charge of your unpaid and owed balance may be assessed each month. Please realize that failure to keep your account current may result in your account being referred to a collection agency or a lawyer. In case of default of payment on this account, you agree to pay all collection and legal fees incurred in order to collect the current amount owed.

Returned Checks:

A returned check fee of \$30.00 will be applied to each returned check. If we receive more than 2 returned checks, we will request all payments be made in cash, credit card or money order.

By signing below you acknowled understand the information presented, a satisfactorily.	edge that you have read this document, and have had all your questions answered
Patient/Parent Signature:	Date:

NECESSARY APPOINTMENTS

Patient Name	

# Units	Dental Treatment	Return	Scheduled	Comments
				Comments
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