AMMAR C. LOULY, DDS-MSD

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you are consenting to allow Louly Dentistry/SNMI to use and disclose your protected health information in order to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a 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: loulydentistry@aol.com
Address: 11530 East Washington Street
Indianapolis, Indiana 46229

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE SECTION

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following

Personal Representatives Name _____

Relationship to Patient _____

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

LOULY
DENTISTRY

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.

Insurance:

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 acknowledge that you have read this document, understand the information presented, and have had all your questions answered satisfactorily.

Patient/Parent
Signature:_____Date:_____

NECESSARY APPOINTMENTS

Patient Name ______________________________

# Units	Dental Treatment	Return	Scheduled	Comments