KANG DENTAL

OFFICE POLICY

We are committed to providing you with the best possible care. In order to achive these goals, we need you assistance, and your understanding of our office policy.

Payment for service is due at the time services are rendered. We accept cash, personal checks, all major credit cards and some third party financing. Accounts are considered past due after 30 days. There is a $25.00 charge for returned checks. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits.

For all procedures, no matter the amount, our fee is due (your co-pay portion), we will process the insurance claim for you, and you will be responsible for thebalance not paid by the insurance by your next appointment. We will gladly discuss your proposed treatment and answer any question relating your insurance.
You must realize, however, that:

1. Your insurance is a contract between you, your employer and your insurance company. We are not party to the contract.
2. Our fees are generally considered to fall within the acceptable range for this region for general practice.
3. Not all services are covered benefit in all contracts. Some insurance companies arbitraily select certainservices they will not cover.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your resposibility from the date of the services rendered.

I understand that if I need to change as appointment, I must do so two business days prir to my reserved appointmant; otherwise there will be a fee of $50.00

Patient or Guardian Signature:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete desription of the uses and disclosures of my health informaion. 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 obtain a current copy of the Notice of Private Practices.

I understand taht 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 or Guardian Signature:_____ **Date:**_____