DIPLOMATES, AMERICAN BOARD OF PERIODONTOLOGY

DR. YU & ASSOCIATES
PRACTICING THE FINE ART OF PERIODONTICS & IMPLANTOLOGY

DAVID H. YU, DDS, MS
NICOLE S. LITIZZETTE, DDS, MS

Patient's Full Name: ______________________________________________________ Date of Birth: ________________

## Acknowledgement of Privacy Practices

By my signature below, I acknowledge that I have read the Notice of Health Insurance Portability and Accountability Act (HIPAA) and Financial Policy of Dr. Yu and Associates that is available to review upon request. I understand that Dr. Yu and Associates reserves the right to change their notice and policies, & upon request will mail a copy of any revised notice to the address I have provided. Under the HIPPA, I understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I may revoke this consent in writing, except to the extent that Dr. Yu and Associates have already taken action in reliance thereon.

______________________________________________ __________________

Signature of Patient, Parent or Guardian Date

## Consent for Services and Disclosure of Health Information

My signature at the bottom grants permission for Dr. Yu and Associates, to call, text or email me on my cell, at home, work, or leave a message to discuss matters related to my treatment. If needed, I give permission for any designated trained employee at Dr. Yu & Associates to take a CT scan (Computed Tomography scan). At your request we can have a Board Certified Maxillofacial Radiologist read your images. I give Dr. Yu and Associates permission to release my information to other medical/dental providers and insurance companies, when necessary, for treatment. In addition to dental/medical providers, I give permission for Dr. Yu and Associates to share my protected health information with the following individuals:

Name: __________________________________________ Relationship: ________________________________________

Name: __________________________________________ Relationship: ________________________________________

## Financial & Cancellation Policy

Full payment of our fees is due at or before the time of treatment. Any pending balance is due within 45 days. In the event of default, collection & legal fees are the responsibility of the patient/guardian. Patients are typically on a waiting list to reserve time in our office. Without proper notice, patients on this wait list do not have the opportunity to fill an open appointment. In an effort to keep costs low, Dr. Yu and Associates reserves the right to charge a fee for any missed, cancelled, or re-scheduled appointments. The fees will be as follows: $100 for surgery appointments with less than five (5) business days notice and $25 for hygiene appointments with less than two (2) business days notice. Our e-mail reminder service is offered as a courtesy. You are responsible for confirming or notifying us of any issues regarding a scheduled appointment. If you have questions about our financial or cancellation policy, please call and speak with us personally.

____________________________________________ _________________

Signature of Patient, Parent or Guardian Date

## For patients with Insurance

We are able to file a dental claim with most dental insurance companies; however, we are out of network providers. As a courtesy, we will file a dental claim on your behalf for services performed in our practice with your primary dental insurance ONLY. We will provide any necessary documentation & radiographs to you or your dental insurance company to help with claim processing. Your insurance is a contract between you and the insurance company. We are not a party to that contract, nor can we become involved in disputes between you and your insurer regarding the payment. Dental insurance benefits quoted to you or our practice are ONLY ESTIMATES provided by an insurance representative, NOT A GUARANTEE OF PAYMENT. We are unable to submit to your secondary dental insurance; however, we are required to disclose knowledge of any secondary dental insurance to your primary dental insurance carrier.

Do you have secondary dental insurance? YES/NO. If yes, please provide a copy of the insurance card.

Should there be an account balance, I hereby authorize my insurance company to pay any benefits due from my claim directly to the provider for services rendered to me or my dependent by Dr. Yu and Associates.

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Signature of Patient, Parent or Guardian Date