

Notice of Privacy Practices Policy

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specially, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. WE balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the E.S. Department of Health and Human Services. www.hhw.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, E-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

/ /

(Parent/
signature)

Guardian’s
Date



**Pediatric Dentistry
of Atlanta**
Achieving Healthy Smiles Together

Print child(ren)’s name(s)

Appointment Policy

At A+ Pediatric Dentistry of Atlanta, your time is highly valued. Our intention is to begin your appointment on time and to work efficiently toward our collective goal of healthy smiles. We are committed to spending the entire reserved time with you! For this reason, we ask that you arrive at our office a few minutes early to check in, use the restroom, or let your child get comfortable in our play area. *If you must cancel or change your appointment, we ask for a minimum of 24 hour advanced notice from your appointment time.*

Fillings, Sealants, and Sedation

Before scheduling an appointment for fillings and/or sealants, we will collect a reservation installment of \$50.00 that will go directly toward the cost of your child’s treatment. If sedation is necessary, we will collect an installment of 1/3 of the sedation fee before scheduling an appointment. *In the event we do not receive 24 hour advanced notice, you forfeit your reservation installment.*

Multiple Broken Appointments

If 2 or more scheduled appointments are broken or cancelled (within 24 hours), certain appointment times will be restricted for future appointments for the next 12 months.

Consent for Treatment

I hereby authorize Dr. Jaha Howard to administer any treatment and to perform such x-rays and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all costs of dental treatment.

I hereby authorize my insurance benefits to be paid directly to A+ Pediatric Dentistry of Atlanta.

Your signature indicates that you agree to the office policy listed above.

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time, financial arrangements will be made before treatment is rendered.

Parent Signature

Jaha V. Howard DDS, MS

Date