SHAPIRO
FAMILY DENTISTRY
"Creating Miles of Smiles"

Date: _____ Home Phone (____) _____

Cell Phone (____) _____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID #_____
Last First Middle Initial

Address_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Email:_____ ☐ Separated ☐ Divorced ☐ Partnered for ____ yrs

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer Phone_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified? _____Phone_____

Pharmacy Name & Address: _____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last First Middle Initial

Relation to Patient_____ Birthdate_____ SS#_____

Address if different from Patient's_____Phone _____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

HELP US HELP YOU

Do you like your smile? _____ Yes _____ No

If you could change your smile, what would you like to change?

_____ The color of my teeth _____ Close spaces or restore worn and broken teeth

_____ The shape of my teeth _____ The position or alignment of my teeth

_____ Other, please specify: _____

I am interested in: _____ Teeth Whitening _____ Cosmetic Evaluation _____ Replacement of Missing Teeth

_____ Straight Teeth _____ White Fillings _____ Breath Control

_____ Other, please specify: _____

This office charges a missed appointment fee of $50.00 - we appreciate a 48-hour courtesy call to cancel your appointment.

SHAPIRO FAMILY DENTISTRY
"Creating Miles of Smiles"

Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Address:_____ Phone:_____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:_____ Reason for surgery:_____
Date of surgery:_____ Reason for surgery:_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____
Sleep Apnea?	Yes	No	Relationship _____				

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug or food allergies not listed above: _____

Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____
Marijuana? Yes No How often? _____
Recreational drugs? Yes No How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent, guardian Date

_____ _____
Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____

STATE OF FLORIDA DEPARTMENT OF HEALTH NON-COVERED SERVICES FORM

Shapiro Family Dentistry practices quality dentistry. We will treat you as we would treat ourselves. We will provide you with a plan of treatment prior to your procedure and will make every reasonable attempt to estimate your copayment. Unfortunately, this is only an estimate, and you must be aware of the following:

SHAPIRO FAMILY DENTISTRY HAS ADVISED ME THAT THERE MAY OR MAY NOT BE COVERED SERVICES TO TAKE CARE OF SOME OF MY DENTAL CONCERNS BECAUSE OF THE FOLLOWING:

1. Most insurance plans have deductibles.
2. There may be contractual changes between the insurance company and your employer.
3. Your insurance company may not pay for the best treatment, for instance they may pay for metal crowns and not porcelain crowns on your back teeth, and they will not pay to replace teeth missing prior to coverage.
4. Some insurance companies pay for two cleanings a year, others one cleaning every six months and a day.
5. Although it has been shown that the mercury and silver has been classified as potentially dangerous, some insurance companies will pay for only mercury fillings on back teeth. We feel this is wrong and may affect our patient's health and therefore do not place mercury fillings.
6. Some insurance plans have waiting periods (some up to two years) before they will pay for anything but a simple cleaning.
7. some insurance representatives failed to provide the correct information, others refused to fax benefits or coverage verification to her office for our records and most refuse to tell us when your last treatment at another dental office occurred.
8. Although x-rays are diagnostic and necessary and payable at 100% with no deductible by some insurance companies, the same company will not pay 100% and apply a deductible.
9. The panorex x-ray is used to diagnose abnormalities and infections of the jawbone and face. This x-ray provides a two-dimensional image of your mouth and exposes parts of your jaw and face that cannot be seen with traditional dental x-rays. It gives us a view of the entire upper and lower jaw including the temporomandibular joint (TMI), the nasal sinuses and their surrounding bone. It also shows the mandibular nerve, which provides sensation to the teeth and gums of the lower jaw. It is used for the early detection of oral cancer which may not become evident until it's advanced. A panorex x-ray makes it easier to see cysts and tumors in the jawbone whether benign or malignant. It helps the dentist locate fractures and trauma to the jawbone, and in children determines whether the permanent teeth are developing properly beneath the primary teeth. It is used to see the location and angle of the wisdom teeth and how they are affecting the teeth in front of them. Therefore, the panorex x-ray is an integral part of the patient examination. The panorex x-ray is not as precise as the usual dental x-rays and therefore it is still necessary to take the usual dental x-rays to check for dental problems pertaining strictly to the teeth and surrounding structures such as cavities or periodontal disease. Insurance companies may or may not pay for both types of x-rays and sometimes combine the benefits for these procedures even though they are not the same. I understand that should this occur I agree to be responsible for payment of the balance not covered by insurance.
10. My insurance company routinely downgrades my child’s resin composite filling to amalgam restorations containing mercury.
11. My insurance company routinely bundles necessary x-rays into a full mouth series which can be as old as 3 years and is no longer diagnostic to my child’s needs.
12. My insurance company routinely disallows cavity finding x-rays which are deemed necessary by Dr. Shapiro.
13. My insurance company routinely denies debridement / deep cleanings, medications and rinses.
14. My insurance company does not provide orthodontic coverage unless my child’s condition creates a disability and impairment to their physical development.

We hear time and time again: "my insurance pays for everything." This is not true. And we did not choose your insurance company, nor are we employees of your insurance company. This office will submit your claim as a courtesy to you. We will send necessary documentation and x-rays when requested. If your insurance company fails to pay your claim within 30 days, you will be responsible for payment in full. Please remember your insurance company is a business and wants to make a profit.

I have read and understand the above and it knowledge responsibility of payment should my insurance company failed to pay my claim for any reason.

AFTER THE EXAMINATION, A TREATMENT PLAN WILL BE EXPLAINED TO ME WHICH WILL ESTIMATE WHAT MY INSURANCE SHOULD PAY AND WHAT MY COPAYMENT WILL BE AT TIME OF TREATMENT, AND I AGREE TO PAY FOR ANY DENTAL SERVICES PROVIDED BY DR. SHAPIRO THAT MY INSURANCE COMPANY FAILS TO PAY.

_____ _____

Patient/Guardian Signature **Date** **Print Name** **Relationship to Patient**

Patient Name:_____ **Date of Birth:_____**

Financial Policy

This financial policy contains important information about billing and payment for our professional services. It outlines your responsibility as the patient and our responsibility concerning billing and payment for our services.

- ✓ Our practice participates with many health insurance companies. Our business office will submit the claim for any services rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our Dentists are participating in their insurance plan at time of service. **The burden of proof is the patient's responsibility and not the Dentist responsibility.**
- ✓ If patient is a member of an insurance plan with out-of- network benefits in which we do not participate, our office will also file the claim on the patient's behalf; however**, the patient is expected to make payment in full at time of service**.
- ✓ It is the patient responsibility to make payment at time of service for co-payment or deductible. Any services not covered by patient's insurance plan are the patient's responsibility and payment in full is expected at time of service.
- ✓ It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral, the patient's visit may be rescheduled, or the patient may be personally responsible for payment for the services rendered by Our office.
- ✓ If you request the completion of medical forms or special letters from the Dentist, we may be charged at least $50.00 per form/letter for duplication.
- ✓ **Please, understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving the care they need. Therefore, our office may charge a fee of $50.00 for appointments not cancelled with 48 hours' notice.**
- ✓ Payment for professional services can be made by cash, credit card, debit card, or through special third-party financing with Care Credit (subject to credit approval).
- ✓ Major procedures may require a reservation fee up to $100 to secure a specialty appointment which may be non-refundable if appointment is canceled or changed without 48-hour notice. This reservation fee will be applied to your dental treatment received.

Insurance & Insurance Collections: Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. Some services provided may be considered non-covered and may not be payable by your insurance plan. Your insurance policy is a contract between you and your insurance company. **If your insurance company has not paid your account in full within 60 days, the balance of your account will be due**. It is the patient's responsibility to make sure the insurance reimburses the doctor for services rendered. Unresolved balances may be placed with an outside collection agency. The unresolved balances may also be subject to finance charges, attorney fees and collection agency fees. Once the account has been placed in collections, future appointments may not be made until you see or talk to a representative in our billing office, but emergency care will still be rendered

Non-Contracted or Indemnity Insurance Plans: Payment is due at time of service. Our office as convenience and service to you, will absorb all cost incurred for billing and filing the claim with your insurance company. Your insurance company will reimburse you directly for any payments made to our office.

HMO Plans: All co-pays must be satisfied every visit. There can be no exceptions due to contracting and compliance rules. You are responsible for getting the proper referral information before your appointment.

PPO Plans: Our office as a convenience and service to you, will absorb all cost incurred for billing and filing the claim with your insurance company. We have agreed to accept the discounted rate from your plan; however, co-insurance and deductible is your responsibility. There can be no exceptions due to contracting and compliance rules.

MEDICARE: As a participating provider, we may bill your Medicare carrier. You are responsible for your co-insurance and your yearly deductible. There can be no exceptions due to contracting and compliance rules.

Secondary Insurers: having more than one insurer DOES NOT necessarily mean that your services are covered 100%. You are responsible for filing any claims to your secondary carrier. Secondary insurers will pay based on what your primary carrier pays. You are responsible for any balances or deductibles not covered under your primary insurance.

Self-Pay: Payment is due at time of service. You have the right to ask how much the service will cost before receiving it. Accounts owing for 60 days or more may be placed for collections. A monthly collection fee of $25 will be added as permissible by state and federal laws.

Patient Name:_____ **Date of Birth:_____**

To enhance communication and promote understanding regarding this office is financial policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the office manager. Thank you!

- ✓ **Insurance**: We are happy to bill both primary and secondary insurance out of courtesy for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portion do; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement.
- ✓ **Patient Payment**: The patient portion due for services rendered is expected at the time of service unless previous arrangements have been made. We except cash, checks and all major credit cards.
- ✓ **Financing**: We have financing options available through Care Credit. If you have an interest in this option, please consult with the office manager prior to the date of the schedule treatment.
- ✓ **No-shows/missed appointments**: We request notice to cancel or reschedule appointment of at least 48 hours (two business days) prior to the appointment as scheduled. If appropriate notice is not given, a charge of $25 per hour of scheduled appointment will be assessed of the patient's account (example: 1 hour or less appointment = $25 charge, 2 hr appointment = $50 charge, etc.)
- ✓ **Refunds for Unfinished Treatment**: If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or dentist.
- ✓ **Credits on an Account**: If insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- ✓ **Collections**: On occasion, after repeated attempts to collect the balance due, we may need to turn in account over to a collection agency. Should this occur, it was agreed the financially responsible party pays all finance charges, collection cost, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information 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, and the uses and disclosures me may make of your protected health information. A copy of this Notice accompanies this Consent for you to take with you. 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. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practice including any revision at any time by contacting us by phone or by mail at the above address.

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 revocation of this Consent will not affect any action we took in reliance on the Consent prior to receipt of you revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

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 your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I have read, understand and agree to the Financial Policy and Disclosure of Health Information. I understand a billing representative is available to me if I have any questions. I also acknowledge receipt of Shapiro Family Dentistry Notice of Privacy Practices.

_____	_____	_____
Signature of Patient	**Name of Patient**	**Date**

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your health information to military authorities of the armed forces under certain circumstances. We may disclose to authorized federal authorities/official's health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders such as texts, voicemail messages, postcards, or letters

PATIENT RIGHTS

Access: You have the right to view or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies we will charge you .99 cents for each page, $ n/a per hour for staff time to locate and copy your health care information, and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. Duplication of x-rays are $25.00.

Disclosure accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 5 years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests. Shapiro Family Dentistry has adopted an office policy due to the extensive amount of time and paperwork involved in insurance billing. Shapiro Family Dentistry will continue to submit claims as a courtesy, however, if we fail to receive payment within 30 days from your insurance company, we will then bill you directly including collection costs if applicable. Payment will be due 14 days from the date of your statement. Due to Florida requirements regarding disposal of biomedical waste and the costs required to comply with this requirement our office charges an infection control fee to cover the necessary time, paperwork, and costs to comply with this Statute including removal of biomedical waste for the protection of our patients. We will invoice your insurance company accordingly. Some insurance companies request invoicing for crowns (2750/6750 and other dental procedures associated with laboratory fees), on insertion dates, some (Cigna) on preparation dates, and some (MetLife) plans on insertion or preparation depending on the plan. In light of the above, and the difficulty ascertaining which date to use, this office will unilaterally invoice your insurance company on the preparation date as this is the date the laboratory fee is incurred. If you do not have insurance, we will invoice you on day of impressions for any laboratory work. We adhere to all fee schedules as a contracted provider for insurance plans and you must understand that your carrier may pay less than the actual amount submitted. You agree to be responsible for payment of all services rendered on your behalf and on the behalf of your dependents and agree by your signature below that you assign all insurance benefits to Shapiro Family Dentistry, if any, otherwise payable to me for services rendered, and that you authorize your signature on all insurance submissions on your behalf.

The undersigned acknowledges that all accounts are due and payable within 30 days. An interest charge of 1.5% per month will be applied to any unpaid balance after thirty (30) days. In the event this account is in default, patient agrees to pay all cost of collection, including collection agency fees, court costs and attorney's fees, whether suit is filed or not. In the event a suit is filed, venue will be Palm Beach County, FL.

Administrative Fee: Section 466 of the Florida Statutes requires that "patient records kept in accordance with this section shall be maintained for a period of 4 years from the date of the patient's last appointment." This office charges an administration fee which covers the necessary time, paperwork, and storage facilities, to comply with this Statute and the operation of this facility including the preparation and furnishing of all paperwork necessary under provisions of the statute and applications for licensing to operate radiographic equipment (x-rays), renewal and payment of all licenses, state, county and city fees, and required reports and credentialing requirements for the operation and continued compliance of this dental office, and/or removal of biohazardous waste, and infection control, and sterilization monitoring and the increased cost of dental products due to the new Federal Excise Tax. Should any patient wish to review the results of our sterilization monitoring tests please call office manager at (561) 684-2282 and she will make them available to you. This fee is charged on EACH APPOINTMENT.

Your signature below indicates that you have read and understood the above Administrative Fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must specify why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

Signature of Patient **Name of Patient** **Date**