LAPINSKI DENTAL

349 L Route 206 Hillsborough, NJ 08844
Office (908)874-7050 Fax (908)874-8085
www.lapinskidmd.com

Welcome to our office!

Appointments and Cancellations
We make every effort to run on time. Please arrive on time to all appointments, late arrivals may not be seen. If there is a need to cancel an appointment we require at least 24 hours notice. If less than 24 hours notice is given, or you fail to show for an appointment, you will be charged the equivalent of the scheduled procedure.

Payment Information
All co-payments are due at the time services are rendered. Please be advised that we can give you an estimate of what your insurance may pay however if they pay less than estimated you are responsible for the balance. Your insurance company pays us on your behalf therefore after 45 days from the date of service we will close any outstanding insurance claim and bill you directly for the balance. If your insurance company eventually pays us, the amount will be refunded to you. Any outstanding balance that is not paid in full by 90 days from the date of service will be sent to delinquent accounts and the patient will be responsible for their balance plus all attorney fees.

Insurance
Please note that we submit procedures to your insurance as a courtesy. However, it is your responsibility to know the details of your particular plan. Medical and dental insurance are completely different. We estimate all payments and co-payments as close as possible. Please note that you are responsible for charges the insurance company does not cover. Please check with your insurance company to find out if the doctors participate, and for any and all questions regarding coverage, maximums, and deductibles.

Patient Responsibility
I have read and agree to be bound by all of the above office policies. I understand that I am responsible for payment of all services rendered by Robert Lapinski DMD, Lauren Lapinski DMD, or their staff at the time of treatment. I am responsible for any co-payment and deductibles my insurance does not cover. I agree to pay in full for any procedure not covered by my insurance or for any procedure my insurance reduces coverage for due to their alternate benefit policies.

Print Name_____Signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing you rights under this law. You have the right to review our Notice before signing this consent (it is hanging in our waiting room). You may also request a copy. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have a right to request that we restrict how health information about you is used or disclosed for treatment, payment, or health care operations. By signing this form, you consent to our use and disclosure of health information about you for treatment, payment, and health care operations. You have a right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPPA).

The patient understands that:

- Health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Patient may condition treatment upon execution of this Consent. **No insurance can be billed on the patient's behalf without this signed HIPPA consent form, therefore same day of service payment in full for any services will be required.**

Print Name_____Signature_____Date_____

For Office Use Only We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
O Individual refused to sign O Communications barriers prohibited obtaining the acknowledgement O An emergency situation prevented us from obtaining acknowledgement
O Other (Please Specify) Updated 5.23.2012