Altamonte Implant & Cosmetic Dentistry
Oral Implantology Associates, PLLC
Atila C. Miranda, D.D.S

Oral Implantology Associates & D5 Dental Policy

Welcome! Thank you for choosing Oral Implantology Associates as your dental provider. We are committed to the highest quality of care at most reasonable fee. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy. All patients must complete our Registration and Health History form before having any treatment/consultation. The following is a statement of our Financial Policies which require you to read and sign prior to any treatment. If an attorney is retained for any uncollected balance, all attorney and court costs will be your responsibility.

FULL PAYMENT IS DUE AT TIME OF SERVICE

FINANCIAL AGREEMENT: Patients are expected to pay for our services at the time they are rendered. Payment is to be paid in full at time of service or prior if surgery is involved. Payments may be made using cash, check, Amex, Visa, MasterCard and/or Discover. We also offer CARECREDIT and LENDING CLUB, which is a financing option that are available only for healthcare expenses.

Insurance Policy

We are a fee for service practice. We are a non-contracted provider with all the dental insurance companies. **As a courtesy** we'll help you file a claim with your insurance company. All our patients are responsible for the service fees at 100% at the date of service. The insurance company will reimburse the subscriber at the percentage they cover the procedure. Your insurance policy is a contract between you and the insurance company. **WE DO NOT FIGHT CLAIMS.**

Policy for NO SHOW or Late Cancellation of a Scheduled Hygiene or General Dentistry Appointment

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. If you have a conflict in making your appointment, call 48 hours in advance. If you NO SHOW or do not give the office 48-hour notice, then your account will be charged a $50.00 fee for missed appointment. This fee will be due before any further appointments are scheduled.

Policy for Dental Implant or Surgical Appointments

For these longer timed appointments a 10% non-refundable deposit is required. There is a 72-hour advanced notice required to cancel an implant or surgical procedure. The 10% deposit will be forfeited if 72 hours advanced notice has not been given to cancel the appointment. D5 (All on Four) dental procedure a $5,000 deposit is required if you are wanting a specific date for your surgery. The remaining full balance will be due at your pre-op appointment.

Policy for CT Scan

CT Scans taken at our practice are for IN OFFICE USE ONLY. CT Scans are done for patients as a complimentary procedure when implants are involved. If the patient would like to have a copy of the CT Scan the fee is $300.

Patient Only

Patients will be the only one allowed in operatories. Exceptions include special needs patients and those that need translation. All other exceptions will be at the decision of the dentist. Failure to comply with this may result in the rescheduling of your dental appointment.

After hours' emergency visits

Any after-hours emergency visits will be charged **$150.00** emergency fee plus cost of treatment. Payments for these visits are due at the time of the visit with cash or credit card only.

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns.

I have read Oral Implantology Associates, D5 Dental Policy. I understand and agreed to this financial policy and accept that services rendered and payment is for both part of treatment.

Patient Name (print): _____

Patient Signature: _____

Date: _____

HIPAA Privacy Consent Form
Altamonte Implant & Cosmetic Dentistry
D5 Dental Group Florida PA
Atila C. Miranda, D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain, by your signature, that you have reviewed our notice.

The terms of the notice may change. If so, you will be notified at your next visit to update your consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.

By signing this form, I:

- Acknowledge the receipt of a copy of the current effective Notice of Privacy Practices.
- Understand that protected health information may be disclosed for treatment, payment or healthcare operations.
- Understand that the practice reserves the right to change the privacy policy as allowed by law.
- Understand that the patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Understand that the practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? YES OR NO

May we leave a message on your voice mail at home or on your cell phone? YES OR NO

May we send x-rays via email to specialists you have agreed to see? YES OR NO

May we discuss your conditions with any others, including members of your family, friends or healthcare team? YES OR NO

If YES, please list those individuals (Note: we can **only** discuss conditions with those listed here):

_____

_____

_____

Patient Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____