NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (”HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly:**
- **Obtain payment from third-party payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

PHOTOGRAPHY RELEASE

I, _____ , hereby authorize Dr. Janée Atkinson and/or her associates or staff members to take photographs, slides, and/or videos of my face, jaws and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my treatment, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication), social media (office Facebook page), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Patient’s Signature **Date**

Janée G. Atkinson, DDS
4303 Texas Blvd, Suite #1
Texarkana, Texas 75503
903 792 0760

Information for our Patients with Dental Insurance

Dental Insurance is playing a larger and larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you. We consider our relationship with you to be of primary importance and will always make our recommendation to you based on what we believe is the very best treatment for you regardless of your insurance coverage. We will assist in any way possible to maximize your dental insurance benefits. We will gladly file your insurance for you but to re-emphasize, we have no relationship or responsibility to your insurance company.

FACT #1: Dental insurance is not meant to be a “PAY-ALL”, it is only meant to be an aid.

FACT #2: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

FACT #3: Some routine dental services are NOT covered by insurance carriers. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any question regarding our services and/or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of your maximum benefits. If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

Payment
Payment is expected at the time of service. If you have insurance, you will be expected to make an estimated payment for that portion not covered by your insurance plan. For that portion of costs not covered by insurance, we offer several payment options.

Cash or Personal Check, Credit Card, Visa, Discover and American Express or Care Credit Medical/Dental Card - Care Credit offers 3, 6 and 12 month interest-free payment plans, and extended financing up to 48 months. You may apply in our office or apply online.

Patient Name _____

Relationship to Patient _____