Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Ingrid R. Janssen, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Ingrid R. Janssen, DDS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Ingrid R. Janssen, DDS
3701 - A Ensign Road NE * Olympia, Washington * 98506 * 360-438-2735

Janssen Dental

FINANCIAL POLICY

We request that all fees or co-payments be paid at the time of treatment unless financial arrangements have been agreed upon in advance with our financial coordinator. For our patients with dental insurance, we will happily assist you in determining the benefits of your coverage. However, since your insurance policy is an agreement between you and your insurance company, we cannot guarantee estimated coverage or payment. You are ultimately responsible for all charges. We will do all we can to see that you receive the full benefits of your policy.

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your insurance coverage can be very difficult. Our goal is to assist you in maximizing your benefits. We care for patients with coverage from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our financial coordinator can serve you in these ways:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Estimating your dental benefits based on the information you have provided us.
3. Re-filing your insurance a second time within 60 days if needed.
4. Following the ADA guidelines for coding procedures and insurance filing.

Our expectations of you as the policy owner:

1. Payment of fees not covered by your insurance plan at the time of service unless otherwise arranged with the financial coordinator.
2. Understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realize that insurance policies restrict payment for some services, use restrictive fee schedules and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on premium paid for your insurance and not our fees or recommended treatment.
4. Take responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keep our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please bring your insurance booklet and card with you to your visit to help us maximize your benefits.

I hereby authorize payment directly to Dr. Janssen of the Insurance Benefits otherwise payable to me.

X_____

Signature Date

Janssen Dental

TREATMENT CONSENT FORM

Thank you for selecting Dr. Janssen's office to provide your dental care. We assure you that all personal health information will be kept private. To ensure your safety, it is very important that you provide us with an accurate and complete medical history and that you inform us promptly of any changes. Medical updates must include ALL health conditions, medications and allergies.

In order for Dr. Janssen to provide you with quality care, it will be necessary to obtain x-rays, complete a full examination and prepare a list of treatment recommendations for you. It is our goal to thoroughly explain all recommended treatment to you. If you don't fully understand and accept the recommended care, it is the patient's responsibility to ask questions.

While our office takes every reasonable step to limit any complications with your dental treatment, please understand that no treatment is completely risk free, especially when using anesthetics. Some complications that may occur include tooth, gum or jaw soreness, lingering numbness, temporary increase in heart rate, headache, swelling, bleeding, or unpredictable findings that could require a specialist's involvement (such as a root canal or extraction of a hopeless tooth).

I UNDERSTAND THE TREATMENT RECOMMENDED AND ACCEPT ALL CARE. I HAVE READ THE POTENTIAL RISKS AND COMPLICTIONS THAT CAN OCCUR. I WILL INFORM DR. JANSSEN'S STAFF OF ALL MY MEDICAL CONCERNS AND ALLERGIES. I GIVE CONSENT FOR TREATMENT TO JANSSEN DENTAL.

X_____

Signature Date

Comments/concerns_____

_____

_____

Cancellation Policy

Dr. Janssen and her staff members work very hard to make each of your appointments comfortable and pleasant. Occasionally, due to emergencies or circumstances beyond our control, we may run behind. We do value your time and will do our best to get you back in a treatment room at your appointed time.

Also, we ask our patients to be considerate of our time. The appointments scheduled for you are part of the limited time that we have available to treat patients each day. Our staff works very hard and counts on you to be on time for each appointed visit. If you need to cancel an appointment, we do require a minimum of **24 hours notice**. That enables us to offer the designated time to another patient with dental needs. With inadequate notification, we are often unable to fill the appointment time.

We reserve the right to charge patients a $50.00 cancellation fee if notification is not given 24 hours prior to the appointment in question. We do realize that emergencies come up and you are not always going to be able to give that amount of notice. If this situation happens to arise, please call us and let us know as soon as possible. We give all patients one courtesy missed appointment before charging the $50.00 fee, but would appreciate never having to use it.

While we find it unpleasant to have to charge our patients, anything less than 24 hours notice really does leave us in an awkward position. We strive as an office to perform with the highest standards possible to achieve the high quality care that Dr. Janssen provides.

I HAVE READ AND UNDERSTAND DR. JANSSEN'S CANCELLATION POLICY AS STATED ABOVE:

_____

Signature Date