Dr. Jack Ohanesian D.D.S.
Our Financial Policy

Our goal is to provide you, our patient, with the highest quality dental care at an affordable cost. At your examination, the doctor will discuss with you in detail what treatment he feels is best for your oral health. Our financial coordinator will then discuss with you the ***estimated*** cost of that treatment, and what payment options are available. Please be aware that this is an ***estimate*** only, as often the treatment plan can change.

For our patients with ***Dental Insurance***

In order to ***maximize*** your insurance benefits, please provide us with accurate information about your dental insurance, that is, name of the insurance company, insurance carrier, group number, phone number, etc. This will help us more accurately estimate your benefits, and how much out of pocket cost you may be responsible for. Again, this is an estimate only, the final amount the insurance pays can only be determined once they pay. Any over or underpayments on the part of the insurance will either be refunded to you, or you will be billed for the difference. Please remember that you are responsible for the cost of treatment, regardless of any changes in the treatment plan. Please be prepared for any deductibles and/or copayments at the time services are rendered. We accept Cash, Check, Visa, Master Card, American Express and Care Credit.

Although having dental insurance is an excellent way to help pay for some of the cost for your dental care, your insurance company does not dictate what care you should receive. Only the doctor can determine what is best for your optimal dental health. It is important for you and your doctor to discuss what your dental needs are regardless of insurance coverage.

For our ***Non –Insured Patients***

Payment is expected at the time services are rendered.

Failed or Cancelled Appointments

We are aware of the value of your time, and will make every effort to run on time. Likewise, we ask you to respect our time, and ask for a ***48 hour notice*** if you need to cancel or reschedule an appointment. Failure to provide this may result in a $75.00 charge.

We appreciate your confidence in us, and will make every effort to make your dental experience with us a positive one.

Signature of Patient: _____ Date: _____

Dr. Jack Ohanesian D.D.S.
HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 provide safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide your or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of the office to remind patients of the appointments. This may be done by telephone or by any other means convenient for the practice.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.
4. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.
5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or Practice Administrator.
6. Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.
7. The practice agrees to provide the patient with access to their records in accordance with state law.
8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and patient.

If 18 years or older, I consent to have my dental treatment and billing discussed with my parents _____ (initial)

I _____ do hereby agree to the terms set forth above and any subsequent changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

Signature of Patient: _____ Date: _____