POLICIES AND PROCEDURE CONSENT FORM

_____ HIPAA
☐ *Initial*

I consent to the use and disclosure of my protected health information in order to any treatment, payment activities and healthcare operations by Yong and Kim Dentistry. I have the right to read the Notice of Privacy Practices before deciding to sign this consent. This is notice provides a description of the uses and disclosures taken to my protected health information and other important matters about my protected health information. I also have the right to revoke this consent at any time by giving Yong and Kim Dentistry written notice of revocation submitted to the office manager or treatment provider. Notice: Revocation of this consent will not affect any action taken in reliance on this consent before receiving the revocation and that Yong and Kim Dentistry may decline to give treatment or to continue treatment once this consent is revoked.

_____ DENTAL MATERIALS FACT SHEET
☐ *Initial*

I acknowledge that I have been made aware of the Dental Fact Sheet developed by the Dental Board of California. I understand that his sheet is available to me in an effort to ensure that I am fully informed of a variety of materials available for dental restorations. I understand that I should review this information to make fully informed decisions regarding dental restorative treatment. I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with the dentist.

_____ ACKNOWLEDGE UNDERSTANDING /ACCEPTANCE OF FOLLOWING OFFICE POLICIES
☐ *Initial*

1. 24 hours advance Cancellation Policy - Each patient is required to provide advanced notice to allow Yong and Kim Dentistry to arrange the appointments. We do understand that personal emergencies do arise and will always take that into consideration. However, Failure to notify any cancellation of appointments 24 advance will result in a $ 25 fee to patients account. Prior to 24 hours, the patient will be responsible to inform any cancel or reschedule requests by calling or text or leave a message at 714-535-0192. This will allow practice to schedule other patients in wait list or emergency cases.

2. Payment - Copay or payments are due when services are rendered. An estimate of your financial responsibilities shall be provided prior or during your visit.

3. Insurance Claims - We are contracted with most insurance companies and as a courtesy, practice will process insurance claim on patient's behalf, but you are still responsible for the payment of services rendered. Any claim outstanding after 60 days will be billed directly to patient. Any unpaid balance after 60 days will be submitted to collections agency and 3% monthly late fee will be added to the outstanding balances

3. Information updates – Each patient is responsible to update any changes to health, medication, insurance coverage, termination, and /or personal information

Signature (patient or parent/guardian) _____

Today's Date _____