GENERAL CONSENT FOR TREATMENT

I hereby consent to the performance of dental treatment by Johwan J. Doh, DDS, PA. Such treatment will be explained to me and will not proceed without my consent. I reserve the right to ask specific questions before recommended treatment commences. The nature and purpose of the treatment rendered, possible hazards, and alternative methods of treatment will be fully explained to me. I understand the risk involved with treatment. No guarantee, warranty, or insurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of Johwan J. Doh, DDS, PA.

Photographs

Johwan J Doh, DDS, PA may request photographs to be taken for certain procedures. These photographs are for insurance, laboratory, patient education, and advertising purposes. Photographs will not be taken without verbal consent from the patient. All photographs and/or duplications are property of Johwan J. Doh, DDS, PA.

FINACIAL AGREEMENT

I, the undersigned, hereby agree to pay the above named doctor all fees due to him/her for services rendered and/or expenses incurred. Payment is to be made at the time of service or incurring expense unless prior arrangements have been made.

I understand that the payment of my bill is my legal obligation as the patient. I also agree to pay a **cancellation fee** of **$50.00** and up to ½ of the fee for the services to be performed at my appointment, if my appointment is cancelled with ***less than 24 hours notice***.

Please be advised that this office does not offer nor perform amalgam (silver) fillings. If my insurance company chooses to reimburse for amalgam restorations (instead of the more modern, esthetic composite resin restorations), I agree to pay any difference that may exist.

Please be advised that all insurance payment portions are ESTIMATES based on information provided by your insurance company, not a guarantee of an exact payment.

All confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by the insurance company are my responsibility. Any assistance in this matter granted by the above doctor(s), and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmations.

If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty three and one-third percent (33 1/3%) of the unpaid principle and interest that is or becomes due, plus all court costs, and interest in the amount of one and one-half percent (1 ½%) per month, beginning 30 days after the monies have become due or expenses have been incurred. I further agree to pay a *returned check* fee of $35.00 per returned check.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for Johwan J. Doh, DDS, PA. The Statement of Privacy described 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 health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected heath information. The Statement of Privacy Practices is also posted in the facility.

Johwan J. Doh, DDS. PA reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, you will be offered a copy of the revised Statement of Privacy Practices at the time of your visit after the revision becomes effective. You may also obtain a copy of the Statement of Privacy Practices by requesting one be mailed to you.

Initial _____

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT and the state of Maryland. This includes issues relating to your treatment, payment, and our dental care options. Your personal health information will never be otherwise given to anyone --even family members-- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for your purpose.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practices operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSING YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointment including voice mail messages, answering machines, text messages, emails and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

ADDITONAL DISCLOSURE AUTHORITY

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 persons indicated below. Please check 'Yes' or 'No".

ANY MEMBER OF MY IMMEDIATE FAMILY **YES _____ NO _____**

SPOUSE ONLY **YES _____ N0 _____**

OTHER (please specify) _____ **YES _____ NO _____**

_____

Patient Name

_____ _____

Signature of Patient **Date**