



### **The Dentistry in Naples HIPPA Release Form**

This article describes how medical information may be used. Please read carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all healthcare records and other health information used or disclosed to The Dentistry in Naples to be kept confidential. The federal law gives the patient significant rights to understand and control how your health information is used. As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information, how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose health care records for the purpose of treatment, payment, and health care operations. We may use your confidential information to remind you of appointments by sending reminder emails/mailings and/or leaving messages at home/cell/work. Any other uses and disclosures will be made only with your written authorization.

I have reviewed The Dentistry in Naples HIPPA and understand the information to the best of my knowledge. I authorize the release of my healthcare records to be used and disclosed in the manner discussed above. I also give The Dentistry in Naples permission to discuss or release my health care records to the names listed below. If no other individuals are to receive information, please write NONE in the space below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Financial Agreement**

This article describes the financial agreement between patients and The Dentistry in Naples

I understand and will be responsible for all fees involved with my dental care. For patients with insurance, I understand that my policy is a contract between me and my insurance company and The Dentistry in Naples is ONLY a third party that is billing my insurance as a courtesy and convenience for me. I am ultimately responsible for payments for services rendered to me. Treatment plans are estimates ONLY.

Payment is expected at the time services are rendered. I further agree to pay any outstanding balance resulting from insurance non-payment. I understand in the case of any outstanding balance to The Dentistry in Naples for services provided to me my account will be charged late and finance fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_