Rochester Hills Dental
Dr. Donald Ohlsson, D.D.S.
1460 Walton Blvd., Suite 204
Rochester Hills, MI 48309

OUR DENTAL OFFICE PRIVACY POLICY

As dental professionals, Dr. Ohlsson and his staff implemented this Health Information Privacy Policy and Procedures to protect the interest of our patients and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the amended modifications of 2002 and state law that provide greater information are important to us. We will not use your health information for marketing communications. We may use your health information:

- To other dental specialists if you are referred
- To provide you with appointment reminders
- To you or to anyone you designate in writing
- To obtain payment for services we have provided for you
- When required by law

As a patient you have a right to view or transfer your dental records.

If you want more information about the privacy practices of this dental office, or if you are concerned that we may have violated your privacy right, please contact our office or the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information.

Contact officer: Dr. Donald Ohlsson, D.D.S.
1460 Walton Blvd., Suite 204
Rochester Hills, MI 48309
Phone: 248-651-1613
Fax: 248-651-1632
Email: info@rochesterhillsmidentist.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____

Print Your Name / Date

_____

Signature / Date

I, _____, am the "personal representative" and have legal authority to make health care decisions about the following patient:

_____

Please Print Patient Name Here

AUTHORIZATION FOR ADDITIONAL DISCLOUSURE:

I authorize the following individuals to have access to my health information.

Name: Relationship:

1) _____

2) _____

3) _____

_____

Signature / Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of Our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify) _____

INFORMED DENTAL CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any procedures we may, with your agreement, perform. We want to involve you in all decisions concerning any procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures.

Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are many variables involved, some predictable and others not. Complications in dentistry are very low, but they do exist. Even minor procedure like a simple 'filling' can lead to major complication that can't be foreseen. For example, a 'Novocaine' or local anesthetic injection could lead to an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences, but individuals who are contemplating treatment should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read and understand Informed Dental Consent and consent to dental treatment.

Initials _____ Date_____

OFFICE POLICY CONCERNING SCHEDULING APPOINTMENTS

When you make an appointment, we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without 24 hours' notice. The charge will be $50.00.

Initials _____ Date_____

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, American Express and CareCredit.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service unless other financial arrangements have been made by Dr. Ohlsson or the billing receptionist.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Initials _____ Date _____

BILLING POLICY

Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are charged to our office.

Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

I have read the Billing Policy. I understand and agree to this billing policy.

Initials _____ Date _____

We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our polices and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND ROCHESTER HILLS DENTAL ASSOCIATES; INFORMED DENTAL CONSENT, SCHEDULING POLICY, FINANCIAL POLICY, AND BILLING POLICY.

_____
Patient's Name (printed)

_____
Signature of Patient or Responsible Party Date

Dr. Donald Ohlsson
1460 Walton Blvd., Suite 204
Rochester Hills, MI 48309
(248) 651-1613
info@rochesterhillsmidentist.com

RECEIVE APPOINTMENT REMINDERS VIA EMAIL AND TEXT

We send appointment confirmation reminders via email and text.

PLEASE PROVIDE A VALID EMAIL AND CELL PHONE NUMBER

Email Address: _____

Please confirm appointment when you receive the email

Cell Phone: _____

Must reply with "1" when prompted to confirm an appointment