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NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEATH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practice, our legal duties, and out legal duties, and your rights concerning your health information. We must fallow the privacy practices that are described in this Notice while it is to effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practice, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or additional copies of this notice please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider proving treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performances, conducting training programs, accreditation certification licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your Family and Friends: We must disclose your health information to you as, described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your health information we will provide you with information based on a determination using out professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and out experience with common practice to make reasonable inferences of you best interest in allowing a person to pick up filled prescriptions medical supplies x-rays or other similar forms of health information.

Marketing Health Related Service: We will not use your health information for marketing communication without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse or neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary you avert a serious threat to you r health or safety or safety of others.

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National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence counterintelligence and other national security activities. We may also disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request a form to request access by using the contact information listed at the end to this notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosure your health information for purpose other than treatment, payment, healthcare operations and certain other actives for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) You request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny you request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at het end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Please Contact: Discover Family Dental (208) 785-0878

_____ _____

Patient/Guardian Signature/ *Date*

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FINANCIAL & INSURANCE POLICY

I _____, understand that any insurance coverage ESTIMATE given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office.

- Discover Family Dental **ESTIMATES** your payment portion based on the most up-to-date information. Reminder: this is only an **ESTIMATE** and NOT a guarantee.
- Please call your dental insurance company to find out the details of your benefits.

PAYMENTS & FINANCING

- Discover Family Dental requires any amount not estimated to be paid by insurance, to be paid at the time of service. We accept MasterCard, American Express, Visa, Discover, cash and check.
- We offer care credit if you need an extended financing option. Care Credit offers 3, 6, 12 months "same as cash" plans with zero interest.
- After 60 days we charge 1.5% interest each month on the remaining balance unless prior arrangements have been made.

APPOINTMENTS

In the event you need to cancel or reschedule an appointment, we require 1 business day notice to avoid a $25.00 cancellation fee. This cancelation fee will be donated to the Primary Children Hospital. I hereby authorize insurance payments to be dispersed directly to Discover Family Dental / Affordable Family Dental.

_____ _____

Patient/Guardian Signature/ *Date*

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To My Appreciated Patient,

This year marks the beginning of many exciting changes in my office in my effort to improve service and quality of care for you so that you can regain and maintain your health as quickly, efficiently, and inexpensively as possible.

I have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you.

If you cannot keep your appointments and adhere to my treatment recommendations, I will not be able to continue treating you in good conscience.

Therefore, the following policies must be agreed upon:

1. No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. There will be a $15.00 fee added to your account in order to reschedule. If you miss two appointments $30.00 will be added to your account and must be paid to reschedule. This fee is not covered by insurance. This money will be matched by Dr. Jenkins and donated to Primary Children's Hospital.

2. Timeliness is required. We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

3. Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves. We request that you brush your teeth prior to being seated in a treatment room. Toothbrushes, paste, mouth rinse, and floss will be provided for you if needed.

4. If you miss an appointment, you must make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

5. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or wellbeing – we are. We will provide you with an estimate of benefits; however, you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.

6. We run a Zero Balance office. We expect payment in full prior to or at the time treatment is provided. We have several financial options available for all of our patients. If you have any questions, please notify the front office staff.

7. In order to schedule an appointment with Dr. Jenkins, we require 50% of the total patient out-of-pocket expense as a deposit and a signed financial agreement.

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8. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.

9. Upsets: We strive to provide the best care possible for you and your family. However, should an upset occur, please visit with our office manager in an appropriate and cordial manner. She will do all she can do to assure the problem is resolved in a timely manner.

10. Emergencies: It is our goal to eliminate potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this, we would like to define what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms, we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

I greatly appreciate your cooperation.

Yours in Health,

Dr. Jenkins

_____ _____

Patient/Guardian Signature Date