Crosby Family Dentistry * 107 West Main Street * Crosby, MN 56441 * 218/546-6031

FINANCIAL POLICY

To provide you with the highest quality care and still maintain lower prices for our services, we have established this financial policy to assist you in understanding and complying with our clinic's service fees. The patient or patient's guardian is responsible for payment of all services provided by the dental office of Kiefer Miller DDS. Please select the payment plan below:

☐ **I have dental insurance**

Insurance Adjustment
Kiefer Miller D.D.S. is a provider in my insurance network. *(All balances are the responsibility of the patient regardless of insurance.)*

☐ **I would like to use/apply for Care Credit**
Learn more at **https://www.carecredit.com**

☐ **I do not have dental insurance**

Uninsured Patient Courtesy

Receive a 5% discount if payment is received in full at the time of service, by cash or check. The discount does not apply to payments with debit, credit or HSA account cards.

Insurance Claims

Dr. Miller accepts all insurance adjustments from programs which he is a contracted provider. Due to the contractual agreement and negotiated rates with the insurance provider, he cannot provide further discounts.

Dental insurance policies are contracts between the insurance company and the insured. Insurance companies pay only a portion of your dental services, that portion is specified by your insurance contract. It is **your responsibility to verify all insurance policies regarding co-pays, deductibles, and coverage**. All patient co-payments are due at the time of service. We are happy to accurately and efficiently submit all claims to your insurance company. However, in cases where your insurance company has not paid for the services within 60 days, the patient or patient's guardian is responsible for the bill.

Payment for Lab Services

Regardless of insurance status, all procedures requiring a lab service (i.e. crown, bridge, denture, mouthpieces, etc.) will require a 1/3 payment at the initial appointment.

Cancellation Policy

Your time is valuable, and except for emergency situations, you can expect us to be on time for you. We appreciate the same courtesy. It is our policy to charge $50 for failed appointments, and to discharge patients after three failed appointments without 24-hour notice.

We reserve the right to run a credit check on any new patient. An outstanding account balance that exceeds 90 days without payment will result in our collection agency being referred to and dismissal from practice. Patients filing for bankruptcy will also be dismissed. A fee of $30.00 will be assessed on all returned checks.

I have read and understand the financial policies described above. By choosing to proceed with my care, I am also agreeing to comply with these policies. All estimated co-payments provided from your insurance will be due on the day of service.

Patient or guardian signature	Date	Crosby Family Dentistry staff signature	Date

Any remaining account balances after 60 days will accrue a 1.5% interest charge.

Crosby Family Dentistry
107 West Main Street | Crosby, MN 56441 | 218/546-6031 | Fax 218/546-8159 | info@crosbyfamilydentistry.com

MINNESOTA AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

I hereby authorize _____, DDS at _____
(Print Prior Dentist/Dental Office) (Print Prior Office Address)

_____ to release the information in the dental record of _____
(Prior Office Phone Number) (Print Patient's Name)

_____ to Dr. Kiefer Miller DDS, 107 W. Main Street, Crosby, MN 56441, Ph: 218-546-6031,
(Patient's Date of Birth)

Fax: 218-546-8159, Email: info@crosbyfamilydentistry.com.

The purpose of this release of health information is: _____

All information regarding my treatment in your office (check appropriate)

- ☐ between dates _____ to _____, or
  (start date) (end date)
- ☐ related to all treatment

may be released including, but not limited to mental health records, drug or alcohol abuse records, which are protected by state or federal law, or HIV results and related health care issues; if any, except as specifically provided below:

Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed by MN Statue 144.335, Subd. 5. Since the charges change annually, call the Department of Health at 800-657-3793 or at 612-282-6314 for the most accurate amount.

This authorization is effective now and will remain in effect until (date no longer than 1 year). I understand that I may revoke this authorization before the year is over. I understand that I may receive a copy of this authorization.

Patient's Name	**Date**
Signature* (Person Responsible for Patient)	**Relationship, if not signed by the patient** (Parent/Guardian of Minor, Guardian/Conservator of an Incompetent Patient, or Beneficiary or Personal Representative of Deceased Patient)
Print Name* (Person Responsible for Patient)	

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT —PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. we encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at:

Telephone: 218/546-6031 Fax: 218/546-8159
Address: 107 West Main Street, Crosby, MN 56441

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, (print name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operation.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

If you would like a copy, please request one from our office staff after you have signed this form

Section C: Revocation of Consent
(Sign this section when you no longer wish to receive dental care from Dr. Kiefer Miller, DDS)

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that the revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign this Acknowledgment****

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

_____
{Please Print Name}

_____
{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
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

HIPAA PRIVACY FORM 1

Notice of Privacy Practice

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.)

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgment of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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NOTICE OF PRIVACY 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 HEALTH 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 practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/15/03, 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 practices, 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 for 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 providing 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, evaluating practitioner and provider performance, 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 purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect use or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 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 incapacity or emergency circumstances, we will disclose health information based on a determination using 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 our experience with common practice to make reasonable inferences of your 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 Services: We will not use your health information for marketing communications 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 you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may 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 access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.00 for each page, $0.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our free structure.)

Disclosure Accounting: you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six 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 request.

Restriction: You have the right to request that we place additional restrictions on or 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.)** Your 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 your request under certain circumstances.

Electronic Notice: if you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice and written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you were concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you 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 the end of this Notice. You may also 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 the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Heather Cline, Office Manager
Telephone: 218/546-6031 Fax: 218-546-8159
Address: 107 West Main Street, Crosby, MN 56441