HIPAA NOTICE OF PRIVACY PRACTICES &

FINANCIAL ACKNOWLEDGEMENT & CONSENT

Acknowledgement of Receipt

I acknowledge that I have received or have been offered the opportunity to review Leipnitz Dental Clinic's Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed in accordance with: *The Health Insurance Portability and Accountability Act (HIPAA), The HITECH Act, & Wisconsin Statute §146.82.* I understand the Notice describes uses and disclosures for treatment, payment, healthcare operations, and other uses permitted or required by law. Leipnitz Dental Clinic reserves the right to modify its Notice of Privacy Practices. A current copy is available upon request.

Consent for Use and Disclosure of PHI

I consent to the use and disclosure of my protected health information for purposes of: *Treatment*, *Payment*, *Healthcare operations*. I understand I may request restrictions on certain disclosures, request confidential communications, inspect my records, and revoke this consent in writing.

Authorization to Discuss Information with Others

Share with (Name): _____ Relationship: _____

Share with (Name):_____ Relationship: _____

Patient Name: _____

DOB: _____

Signature: _____

Date: _____

If signed by representative, relationship: _____

Patient Communication Authorization

I authorize Leipnitz Dental Clinic to contact me regarding appointments, treatment, billing, and insurance matters via: *Phone*, *Voicemail*, *Text message*, or *Email*. I understand electronic communications carry some privacy risk.

Confidentiality of Alcohol & Substance Use Information (Wisconsin Compliance)

Information relating to alcohol or substance use disclosed in medical history or treatment records is protected under: HIPAA, Wisconsin Statute §146.82, & Wisconsin Statute §51.30 (if applicable). If the practice receives records from a federally assisted substance use disorder treatment program, such records may also be protected under 42 CFR Part 2 and will not be disclosed without specific written authorization unless permitted by law. Alcohol or substance use information is used solely for patient safety, anesthesia planning, healing considerations, and treatment decisions.

Alcohol & Impairment Safety Policy

For patient safety and valid informed consent, Leipnitz Dental Clinic reserves the right to postpone treatment if a patient appears impaired by alcohol or substances that may affect: *Judgment, Consent capacity, Anesthesia safety, Healing outcome.* This determination is made at the provider's discretion.

Financial Policy (Payment Expectations)

Payment is due at time of service unless prior arrangements are made. We accept: *Cash, Check, Credit Card, Debit Card, HSA Card, and CareCredit*

Insurance

As a courtesy, we will submit claims to your insurance carrier. Insurance is an agreement between you and your insurance provider. Not all services we provide are covered benefits. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment.

Missed Appointments

We require 24–48 hours notice for cancellations. Missed appointments may be subject to a cancellation fee of **$50.00**.

Collections

Accounts balances over 30 days past due will be subject to interest. Account balances over 60 days past due may be subject to collections as permitted by Wisconsin law. I understand and agree to the financial policy.

Assignment of Benefits

I authorize payment of dental benefits directly to Leipnitz Dental Clinic for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance.

Informed Consent for Dental Treatment

I authorize Leipnitz Dental Clinic and its providers to perform dental examinations, radiographs, cleanings, anesthesia, and other necessary procedures. I understand: Dentistry is not an exact science, no guarantees have been made regarding treatment outcomes, and risks may include sensitivity, discomfort, swelling, or complications. I consent to treatment as recommended.

Acknowledgement of Receipt of Forms & Agreement to all conditions listed above:

I certify that I have read, understood, and received copies of the above policies.

Patient Name (s): _____

Signature: _____

Date: _____

If signed by representative, list name & relationship:_____