Serenity Smiles

Ash Kaushesh, DDS, MAGD, MaCSD, DDOCS, DABOI/ID
Master of the Academy of General Dentistry
Master of the College of Sedation in Dentistry of the American Dental Society of Anesthesiology
Diplomate of the Dental Organization for Conscious Sedation
Diplomate of the American Board of Oral Implantology/Implant Dentistry

Implants, General, Cosmetic, IV Sedation

Serenity Smiles Financial, Records Release & Privacy Information

Thank you for choosing Serenity Smiles for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need, which allows you to enjoy a healthy, beautiful smile in respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Payment Terms

1. **Full cash payment at the time of treatment**: Full payment for all treatment that is rendered is due (cash, cashiers or credit card) at the time of service.
2. **Full co-pay for insurance companies we are providers for**: Whatever insurance we are contracted or not contracted with, your co-payment is due IN FULL at the time of service including any yearly deductibles that may apply. For some insurance companies with a known history of reimbursing patients directly, the entire payment for the full cost of treatment is due at the time of service as if you were a cash paying patient. If they pay you directly for those service, you must pay us immediately to avoid insurance fraud. As a courtesy to you, we can file a claim with your insurance company so that they can reimburse you directly. If, for any reason the payment is remitted to us, we will reimburse you promptly. It is your responsibility to know your remaining benefits; we can only provide an estimate.
3. **Patients undergoing IV Conscious Sedation**: 1/3 of the treatment plan cost is due at the time that the appointment is scheduled, and rest is due two days prior to the appointment.
4. **Major service - two payment option**: We offer a two-payment option for crown, bridge, and denture treatments. We ask that you pay one-half of your co-payment at the first appointment and the second half at the appointment before the completion of the treatment. A fee is assessed in order to make and keep your appointment for these long procedures.

Broken appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **48 hour business notice to avoid a $50.00 minimum** and then **$50/hour thereafter non-notice cancellation /missed appointment fee** (emergencies and dental pain clinic patients are an exception). **For broken IV sedation appointment, fee is $500 per hour.**

Agreement for Payment and Records Release

I acknowledge full financial responsibility for dental services rendered and I agree to pay what is due in full at the time of service, or to make prior arrangements for payments. If my account is placed for collection, I acknowledge responsibility for associated collection expenses. A 50% collection fee will be added to any balance turned over to the collection agency. There will be a $25 charge for all returned checks. After 30 days, interest will accrue on unpaid balance. I authorize you to release my dental records to my medical doctor and/or to another treating specialist if any referrals are needed, and to release any necessary information to my insurance company for processing the claim. I also authorize you to request a copy or summary of my medical/dental records from other care providers. I request that the payment of benefits be made on my behalf to Serenity Smiles for any services rendered to me by their providers.

Thank you! We appreciate your patronage and your patience. We bill your insurance company as a courtesy to you. We will wait 60 days for the insurance company to remit payment. If it is not paid within this time, the total bill becomes due and payable in full by the person responsible for payment of this account. We suggest you work closely with your insurance company to expedite payment. It is your responsibility to provide them with information requested. Incorrect information will result in a denied claim. It will then become your responsibility to re-file with your insurance company and your responsibility to pay.

A written copy of Privacy Practices of Serenity Smiles LLC has been made available to me (see reverse of this page)

Name	Signature	Date
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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 took effect April 14, 2006, 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 any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. 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 only, 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 our 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 that 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. 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 disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, 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.) 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 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 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 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 the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jennifer Kaushesh
Telephone: 480-400-5000
E-Mail: **info@serenityhavasu.com** Address: 8390 East Via De Ventura Blvd., Suite F200, Scottsdale, AZ 85258