OFFICE POLICIES

INDEMNITY AND PPO INSURANCE

As a courtesy to our valued patients, our office will DIRECTLY BILL INDEMNITY AND PPO INSURANCES for services rendered. We do ask our patients to be prepared to make any payment towards their basic and major services, such as fillings and crowns, at the time these services are rendered. Our practice is committed to providing the best treatment for our patients and to charging what is usual and customary for our area. Please understand that you are fully responsible for all treatments rendered, including services payable by your insurance company as determined by your employer.

DISCOUNTED PLANS

Discounted plans, such as Kaiser, Signature, and Capital Care, are dental plans which allow patients to receive dental services at a discounted price. IN ACCORDANCE WITH YOUR CONTRACT, PAYMENT IN FULL IS REQUIRED AT THE TIME SERVICES ARE RENDERED.

INSURANCE POLICY

Our office will make every attempt to collect payment for your insurance company. In the rare event that your insurance company does not pay within **60 days** of the date of service, the patient will be responsible for the balance in full, which will be charged to the credit card number listed at the bottom of this page. By signing below, you, the patient, authorize Dr. Jason Favagehi, D.D.S., and Associates to charge the credit card listed below with any balances unpaid by your insurance company within **60 days** of the date of service.

TYPE OF PAYMENTS ACCEPTED

Cash and checks are accepted. Please note there is a $40.00 fee for returned checks. The major credit cards American Express, Visa, Master Card, and Discover are also accepted.

SCHEDULING AND CANCELLATIONS

Because we value the time spent with our patients appointments that you make are reserved solely for YOU AND THE DOCTOR. Please give our office the consideration to fill your reservation should you need to cancel. Please allow our office a notice of at least **48 hours** for any cancellations. **Please note that **Saturday and Sunday** DO NOT constitute business days. Any notice less than **48 hours** will be subject to a $75.00 per half hour broken appointment fee

FINANCIAL AGREEMENT

I understand that all information on patient registration form is required to fill out in order to be seen and to the best of my knowledge, the information provided to this office is complete and accurate. I acknowledge that ALL charges incurred in this office are my responsibility and due at the same time. If, for any reason, my insurance should fail to pay for all charges billed, I agree to pay for services upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of 30 days, it may be referred to an attorney for collections, and I will be responsible for all costs incurred, including a 35% attorney's fee (minimum of $50.00) and interest at 1.5% per month (18% annually).

DUPLICATION OF RECORDS

In the event that your records need to be transferred for any reason, you will need to fill out our **Request For Records form**. Please allow our office 3-5 business days for the transfer of your x-rays. We are required by law to keep your records on file for a period of 7 years.

Signature________________________ **Credit Card #**________________________
(OPTIONAL)

Date________________________ **Exp. Date**________________________

Rosslyn Dental Arts Center
1000 Wilson Blvd. Ste. M745
Rosslyn VA 22209
(703)527-6453

Tyson Dental Arts Center
8304-C Old Courthouse Rd
Vienna VA 22182
(703)356-1200

Crystal Smile
2611 S. Clark St. Ste #200
Arlington VA 22202
(571)295-4200

Crystal City Dental Arts Center
1235 S. Clark St. Ste #201
Arlington VA 22202
(571)267-1400

Jason Farr Favagehi, D.D.S.
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our notice of privacy Practice or to document our good faith effort to obtain that acknowledgment.

I, ________________, have received a copy of This office Notice of Privacy Practices.

____

{Please Print Name}

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of privacy Practice. But acknowledgment could not be obtained because:

- ☐ Individual refuse to sign
- ☐ Communications barriers prohibited us from obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other(please specify)

Jason Farr Favagehi D.D.S.

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 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 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. This includes 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.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, Payment and healthcare operation. For example:
Treatments: we may use or disclose your health information to a physician or other healthcare provider treating you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: We may use disclose your health information in connection with our healthcare operation and provider performance, conducting training Programs, accreditation, certification, Licensing or credentialing activities.

Your Authorization: In additional to our use of your health information for treatment , payment , or health care 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. We cannot use or disclose your health information for any reason except those described in this notice.
To Your Family and Friend: 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.

Person Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or location) family member, your personal representative or another person responsible for your care, your location, your general condition or death. If you are present, then prior to 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 an emergency circumstance, we will disclose health information based on a determination using our professional judgment. We will disclose 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 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
Appointment Reminder: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, Postcard or Letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information with limited exception. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically 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 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 $0.05 for each page, $10.00 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 the 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 fee 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 or other activities for the last 6 years but not before April 14, 2003. If you request this accounting more than once in 12-month period we may charge a reasonable fee for requesting to these additional documents.
Restriction: 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).
Alternate 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 by your 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 also 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, if you disagree with the decision we made to access 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. 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.

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We Specialize In the Art of Perfecting Smiles
www.SmilePerfectors.com