ACCOUNT RESPONSIBILITY

- I understand I am financially responsible for my account.
- I authorize Northeast Dental Wellness limited use or disclosure of my protected healthcare information for the purposes of my treatment or care, satisfaction of my account, or situations mandated by law.
- Further, I authorize my insurance company to make payments directly to Northeast Dental Wellness.

Patient Signature: _____ Date: _____

PRIVACY AND SECURITY PRACTICES

We are committed to maintaining your personal information both secure and confidential. Whether it is your medical information or identifiable information like name, address, phone number or identification numbers, we maintain careful safeguards to protect against unauthorized access or fraudulent use.

We may use your individual patient information to coordinate dental treatment with other healthcare providers. To lessen your patient costs, we may disclose personal information to determine insurance eligibility, claim status and payments, medical necessity of your treatment, insurance complaints, appeals or external review requests. Situational uses may include those mandated by law: public health issues, abuse or neglect, legal proceedings, collection efforts, law enforcement, coroners, medical examiners or organ donation programs, research, worker's compensation and/or your employer.

You have a right to confidential communications, a right to request restrictions and a right to access your records. Restrictions can limit our efficiency and ability to help you.

As a creditor, we have a responsibility beyond protecting your information – identifying, detecting and responding to potential warning signs of identity theft or fraud as outlined by the Federal Trade Commission's Red Flags Rule.

DENTAL INSURANCE

In a changing healthcare environment and an era that many dentists do not accept the hassles of insurance, we consciously choose to help our patients seek insurance reimbursement. We understand that every dollar matters. With this decision, comes Federal and State regulations that we must comply with to continue being your advocate.

	Primary Insurance	Secondary Insurance
Policy Holder	_____	_____
Date of Birth	_____	_____
Individual Id or Social Security	_____	_____
Employer	_____	_____
Insurance Company	_____	_____
Group Number	_____	_____
Address	_____	_____