Payment Options
For
The Annapolis Center for Dental Health & Wellness

The Annapolis Center for Dental Health & Wellness strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please understand that this will only be an estimate. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options offered and indicate your choice of payment.

- ☐ **Plan A:** To demonstrate our appreciation for patients who are prompt with full payment by Cash or Check, we will extend a five percent (5%) reduction of the total fee for charges over $125.00. If you have a dental plan, we will bill at the reduced fee.

- ☐ **Plan B:** You may use your credit or debit card to make payment. We gladly accept MasterCard, Visa, American Express, and Discover.

- ☐ **Plan C:** Payment can be made in installments for patients who are established with the practice and have a proven credit history. You can begin your treatment with an initial down payment of fifty percent (50%). The remaining balance may be divided into equal payments based on the number of appointments needed to complete the service.

- ☐ **Plan D:** We are pleased to offer our patients another extended monthly payment plan option through a dental financing company called Care Credit. Please see one of our Financial Coordinators, Connita or Nikki, prior to treatment for more details and to receive a credit application.

- ☐ **Plan E:** Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. Also, remember that dental insurance plans are not designed to cover all of your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer.

- ☐ **Plan F:** For orthodontic care (Invisalign), payment can be made in installments. You can begin treatment with an initial down payment of thirty percent (30%) of the total cost of treatment. The remaining balance to be paid over the course of active treatment (varies per patient).

Again, feel free to contact one of our Financial Coordinators if you have any questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

I, _____, have chosen option _____ (above) and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand this office cannot guarantee my insurance status in any of these areas. Any insurance estimate of information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

This contract is under seal.

Patient Signature: _____ **(SEAL)**

Date _____

Dr. Vernon L. Sheen
Insurance Information

As a professional courtesy to our patients, we will file your dental insurance claims. Dental insurance is not like Medical coverage and rarely covers the same percentages. The professional treatment you receive at Dr. Sheen's office is rendered to you, not the insurance company. You are responsible to pay us for all services/treatment provided. Please understand your insurance policy is a contract between you and your insurance company. Any problems of non-payment or a delay of payment are your responsibility.

Remember, dental benefits were never meant to determine your dental care; they are to assist the patient in the payment of your treatment choice.

You are responsible for all portions not covered by your policy on the day of service.

Because we are a high-tech practice, we will file some claims electronically; therefore a signature on file is required by all dental insurance companies (SEE BELOW).

Any insurance balance over 60 days old is delinquent and is your responsibility to pay.

Accident Insurance cases will be handled by the patient. Patient is responsible for paying for the treatment provided at the time of service. Your insurance carrier will reimburse you directly. Accident claims can take months to settle and we are unable to wait for settlement.

We will always do our best to see that you receive full benefits. However, ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning dental treatment.

INSURANCE INFORMATION NEEDED TO FILE YOUR CLAIM

Insurance Company: _____ Insured SS #_____

Address: _____ Group Number: _____

_____ Plan Number: _____

Phone Number: _____

Employer Name: _____ Supervisor Phone #: _____

Address: _____

Assignment of Benefits
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed: _____

Date: _____

Release of Information
I authorize the release of any dental information necessary to process this claim.

Signed: _____

Date: _____

Vernon L. Sheen, DMD, PA
The Annapolis Center for Dental Health & Wellness
888 Bestgate Road, Suite 201
Annapolis, Maryland 21401

INFORMED CONSENT

1. I, hereby, authorize Dr. Sheen or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. **I grant Dr. Sheen permission to use the above mentioned x-rays, study models and photographs for educational and/or marketing/advertising purposes. *** Initials _____**

3. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

4. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

6. I agree that in the event this account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expenses and court costs incurred in the collection of this account.

7. I understand that if I cancel an appointment with less than 24 hours notice, there may be a failed appointment fee equal to ½ of the total scheduled appointment amount which I agree to pay before any further appointments may be rescheduled.

This contract is under seal.

_____ (SEAL) Date _____
(Patient/Parent/Guardian Signature)

Annapolis Center for Dental Health & Wellness
Vernon L. Sheen., D.M.D., P.A.

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.

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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

Authorization to Release Information

I authorize, _____, _____, to obtain any of my
Print Name of Person **Relationship to Patient**

healthcare information (circle) YES / NO and/or my financial information (circle) YES / NO from Annapolis Center for Dental Health & Wellness (Dr. Vernon Sheen).

Annapolis Center for Dental Health & Wellness
Vernon L. Sheen, D.M.D., P.A.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Appointment Reminders. We may disclose your health information to provide you with appointment reminders (such as voicemail messages, email messages, electronic postcards, or letters).

Marketing Health – Related Services. We will not use your health information for marketing communication without your written permission.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.
Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Connita Wilson or Nikki Fleming

Telephone: 410-266-1007 Fax: 410-266-3850

Address: 888 Bestgate Road, Ste. 201, Annapolis, MD 21401

E-mail: admin@drsheen.com