**Dr. Michele Harutunian D.D.S., P.C. 340 Dogwood Avenue Ste. 110**
**Franklin Square, New York 11010**

# HIPAA CONSENT FORM FOR PATIENTS

*ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIESAND CONSENT FOR DISCLOSURE FOR TREATMENT, PAYMENT AND OPERATION*

## ACKNOWLEDGMENT AND CONSENT

**By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.**

**Patient or Authorized Person Name:** _____
**Signature:** _____
**Relationship:** _____ **Date:** _____

### E-Prescribing Information and Patient Consent

E-Prescribing is defined by a doctor's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. E-Prescribing greatly reduces medication errors and enhances patient safety.

E-Prescriptions are sent electronically through a private, secure, and closed network, so your prescription information is not sent over the open internet or as an email. The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared only for the purpose of providing you with clinical care. E-Prescriptions meet this requirement. The E-Prescription can be sent to the pharmacy of your choice.

**Patient Consent for E-Prescribing**

I agree that the office of Michele Harutunian DDS, PC may E-Prescribe my prescriptions and may request and use my prescription medication history for treatment purposes.

Patients Name (Print): _____
Patients Signature: _____ Date: _____

**Pharmacy Contact Information**

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

# OFFICE POLICY

We will submit your insurance claims to your insurance company and work had to maximize your benefits.

I agree to the following:

- **Any unpaid amount** by your insurance is **YOUR** responsibility. **Any unpaid balance will be charged to the credit card you have on file.**
- **Payment is due in full at time of service.** We accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit.
- There is a $40.00 fee for any returned checks.

You will receive appointment reminders thru text messaging, emails and phone calls before your scheduled appointment.

- I understand that 48 business hour notice (excludes Saturday and Sunday) is required for all scheduled appointments if I need to cancel. If I do not cancel at least 48 business hours prior to my appointment, I will be charged $40 per hour.

Please understand that our time is very much in demand; we set aside a time especially for you and do not overbook. We understand that not everyone is ready to commit to a lifestyle change, but for the consideration of others, please do not wait until the last minute if cancelling your appointment. Please plan accordingly.

I hereby authorize Michele Harutunian DDS, PC to conduct all diagnostic tests necessary and proper so Harutunian DDS may determine and formulate a dental treatment plan. Diagnostic procedures may include but not limited to it and extra-oral photography, x-rays and diagnostic models.

I agree to the treatment, procedures, administration of medications and anesthesia that maybe necessary. I understand that dentistry is not an exact science and therefore dental practitioners such as Harutunian DDs cannot fully guarantee any results. I further agree that all fees for services are due and payable either before or after the treatment at the sole discretion of Harutunian DDS. I shall immediately notify Harutunian DDS of any changes in my medical history (e.g. new conditions, new medications, new allergies, etc.) as well as any changes in my contact information.

I understand that Harutunian DDS reserves the right to change the terms of its Privacy Practices and to make changes regarding all protected health information stored by Harutunian DDS. I understand that I can obtain a copy of Harutunian DDS current Privacy Practices upon request. I understand that in the event that I am unable to attend a dental appointment for whatever reason, Harutunian DDS shall have the right, in its sole discretion, to charge me for such no show appointment.

Patient or Authorized Person Name: _____

Signature: _____ Date: _____