Iris Privacy Practices, HIPAA, Financial Agreement, Pediatric Mediation, Consent and Dentistry Compliance Agreement

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PRIVACY & HIPAA CONSENT
Protected Health Information

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, internal marketing, payment activities and healthcare operations.
Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice, at any time by contacting:

Compliance Officer: Leslie Murray, DMD
Email Address: hello@irispediatricdentistry.com

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

I have had full opportunity to read this Consent form and the Notices of Privacy Practices. By signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, internal marketing, payment activities and health care operations.

CONSENT TO TREAT
Do you allow us to provide care?

Patients and families are essential participants in dental care and we want you to understand your rights and responsibilities while receiving care from us. If you have any questions about this form, please ask your provider. If you are a parent/legally-authorized representative of a child, please read this agreement with the understanding that "T" and "me" means the child. Consent for Treatment I consent to dental care performed by dentist and auxillury staff at Iris Pediatric Dentistry. This includes examinations, diagnostic testing, treatment, and other healthcare services deemed medically necessary in the Providers' professional judgment. I

understand that the practice of dentistry is not an exact science and that diagnosis and treatment may cause injury. I also understand that I have the option to refuse the delivery of healthcare services at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. If I am pregnant, this consent also applies to my fetus. If an emergency occurs during my appointment health care personnel at my location will manage the emergency.
The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique Situations.

- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the dentist. The form also authorizes this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "signature on file". I authorize my dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

- I agree to be responsible for payment of all services rendered on my behalf or my Dependents.

- All confidentiality protections required by law or regulation will apply to my care. I have also received a copy of this office's notice of privacy practices. I am giving my consent to use disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

FINANCIAL AGREEMENT
You are ultimately responsible for all charges. We understand being a parent can be expensive. Please ask us about flexible payment plans!

Payment for services, including deductibles and copayments, is due at the time of the service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards.

Iris Pediatric Dentistry accepts most insurance plans but is only in-network with some plans. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed, in order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or you employer's benefits coordinator for assistance in understanding your plan. It is the responsibility of the patient or guardian to understand the benefits and limitations. We are happy to submit the claims necessary to see that you receive your benefits, but we are only able to submit claims if

all insurance information is provided to the office prior to treatment. Any plans not disclosed or unknown at the time of service will be the responsibility of the patient for claim submission and follow-up.

Please note that dental insurance is intended to cover some but not all dental care costs and not all services are covered by your plan.

You are responsible for payment of all services regardless of the payable benefit.

We have updated our system and now keep a card on file for the convenience of our patients. As
a courtesy we will collect only the estimated patient portion on the day of treatment, and claims will be submitted to your insurance company. Once the claim has been returned we will use the card on file for any charges that remain unpaid up to the total estimate listed on treatment estimates.
If you would prefer to not keep a card on file, you have the option to pay-in-full for all treatment to be completed on the day of service and be reimbursed any overpayment once payment from your insurance company has been received.

We would be happy to discuss our charges and how they relate to your particular situation. Please indicate your understanding and acceptance of these financial policies by signing below.

ASSIGNMENT OF BENEFITS

As a courtesy to our patients we are happy to file claims as long as we have all Information per to the day of service.

Financial Responsibility

I have requested and/or received professional healthcare services from a healthcare provider associated with Practice on behalf of myself or my dependents, and understand that by making this request, I am responsible for charges incurred during the course of said services. I understand that fees for services rendered are due and payable on the date of service and agree to pay such charges according to the arrangements that have been made.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Practice. I certify that the health insurance information that I have provide to provider is accurate as of the date set forth below and that I am responsible for updating all health insurance information.

I hereby authorize Practice and any affiliates on behalf of me and my healthcare provider to submit claims on my, and/or my dependent's behalf to the benefit plan (or administrator to pay directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Practice, I hereby instruct and direct my benefit plan for its administrator) to provide documentation stating such non-assignment to myself and my

provider upon request Upon proof of such non assignment. I instruct my benefit plan for its administrator to make out the check to me and mail it directly to my healthcare provider
I am aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services are paid in full. I understand that I am responsible to pay my deductible and coinsurance

Authorization to Release Information

I hereby authorize my health care provider to: (1) release any information necessary to my health plan (or its administrator) regarding my treatments; (2) process insurance claims generated in the course of examination or treatment and (3) allow a copy of my signature to be used to process insurance claims. This onder will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim right, or cause of action that I may have under such insurance policy andior benefit and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan including but not limited to the right to including, but not limited to, pursuing available administrative appeals or filing suit and all other causes of action on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 CFR 2560.503140 with respect to any healthcare expense incurred as a result of services I received from my provider and Practice and, to the extent permissible by law, to claim on my behalf such benefits, claims, reimbursement, and any other applicable remedy, including fines.

A copy of this Assignment Authorization shall be as effective and valid as the original.

RESOLUTION AGREEMENT & MEDIATION

We pride ourselves on our careful and kind care.
Mediation has been show to expedite the resolution process of any concerns.

We encourage open communication and ask our patients to sign this agreement in which we make contract commitments to each other. It is no surprise that frivolous malpractice claims have a negative impact on healthcare care and can harm the practice and livelihood of a healthcare provider.
Therefore, an additional consideration for professional care provided to me by Provider, the penguardian andor my representative agree not to advance, directly or indirectly, any false mentless, andor frivolous claim of healthcare malpractice against Provider.
Furthermore, in the event of a meritorious malpractice case or cause of action and/or my representative agree to use expert healthcare witnesses practicing in the same specialty as Provider. I agree that these expert witnesses will be members in good standing of their state board

In further consideration for this. Provider agrees to the same stipulations
Patient/guardian and Provider acknowledge that monetary damages may not provide an adequate remedy for breach. Such breach may result in imeparable harm to Provider's reputation and business. Patient/guardian and Provider agree in the event of a breach to allow specific performance and injunctive relief

MEDIATION
While we do not anticipate any issues during the course of your treatment, if any arise, you and your healthcare provider agree to meet with a neutral mediator for a voluntary conversation before starting formal legal action
Should a concern arise regarding the healthcare provided by this office, staff, and affiliated healthcare professionals, I agree to mediate first before pursuing legal action 1 agree that any usage or inference to a "claim" will be understood and read as "potential claim" until mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. I will also not make any demand for payment before mediation begins
1 agree that offering to mediate is a mandatory prerequisite to litigation, and that fea lawsuit without first demanding mediation, the lawsuit should be dismissed without prejudice this perquisite has been met agree that this mediation provision is a material part of this contract
I UNDERSTAND THAT I DO NOT HAVE TO HIRE AN ATTORNEY TO MEDIATE, BUT IF CHOOSE TO CONSULT WITH AN ATTORNEY. I WILL SHOW HIM OR HER THIS PROVISION
Filing in any court by the Provider to collect fees shall not waive the right to compel mediation of any claims.

COMPLIANCE & TEAMWORK
We want you to receive excellent care. The best way to meet this goal is good communication.

YOUR COMMITMENT
Ask questions and be part of your care
Be honest about your health history and symptoms
Tell your doctor about any health changes
Schedule based on the recommended care plan
Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
De respectful to office staff and healthcare providers
End every visit with a clear understanding of your doctor's expectations, and treatment goals

OUR COMMITMENT
Explain diagnosis, treatment recommendations and outcomes in an easy-to-understand way

Listen to your questions
Keep treatments, discussions, and records private
Determine when a breakdown of the doctor-patient relationship is justification for terminating care
Determine when referal to another provider or
Share patient information with other providers involved in your healthcare, as appropriate

I certify that I have read or had read to me the contents of this form. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction