This information packet is for you to keep. Thank you.

DR. RONALD C. FUHRMANN, D.D.S

A division of Atlantic Dental Care

Welcome to the practice of Dr. Ron C. Fuhrmann. In an effort to better acquaint you with our practice, we have outlined the following policies our office upholds.

Office Hours

We are in the office **Monday – Wednesday from 9:00 a.m. – 4:30 p.m** and **Thursday from 9:00 a.m. – 3:30 p.m.** In the event of a dental emergency, please call our office and leave a message as instructed. **Our contact # is: 757-499-8465.**

Financial Policy

For your convenience, we accept cash, checks, money orders and all major credit cards. We also accept CareCredit (a healthcare credit card – please see front desk for details). **Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service.** Returned checks and unpaid balances may be subject to collection placement and collection fees.

Insurance Authorization and Assignment

I authorize Dr. Ronald C. Fuhrmann to furnish information to insurance carriers concerning my dental health. I permit a copy of this authorization to be used in place of the original and request payment of dental insurance benefits to the party that accepts assignment. I understand that I am responsible for any amount not covered by my insurance.
Please note, your insurance policy is a contract between you, your employer, and the insurance. We are NOT a party to the contract. Therefore, we WILL NOT become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary" charges. Also, we will not know if your insurance will cover a procedure until the claim(s) has been submitted.

For those with a benefit plan we will be happy to file your dental claim(s); however, **if after 90 days from the date of service your benefit plan has not paid your claim YOU will be expected to pay the balance.**

Past Due Accounts

If there is a balance on your account you will receive a monthly statement reflecting charges which are 30 days, 60 days, or greater than 90 days past due. For all accounts which are 90 days past due, an 18% APR annual finance charge will be assessed at the end of each month. All accounts needing further collection action will be charged all collection costs and legal fees necessary to collect the debt.

Waiver of Confidentiality

I understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if my past due status is reported to a credit reporting agency, the fact that I received treatment at our office may become a matter of public record.

Missed Appointments

Patients who do not show up for an appointment or cancels with **less than 24 hours Notice will be charged a $50.00 broken appointment fee.** This fee MUST be paid before a new appointment will be given. Patients with **2 missed** appointments may be asked to transfer to another dental practice for future services.

Consent for Treatment

I give authorization to doctor and/or designated staff to take x-rays, study models, or any other diagnostic aids deemed appropriate by Dr. Ronald Fuhrmann to make a thorough diagnosis of my dental needs. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. 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. Also, I consent to fillings without an additional consent form and understand the following: The most common conditions encountered with fillings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, nerve damage, damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems, and occasional allergic reactions to filling materials. Changes in Treatment Plan: During the course of treatment, procedures may need to be added, expanded, or changed if the dentist finds conditions that were not identified during examination and first observed during the course of treatment. The most common scenarios include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges, or implants. Permission is hereby given to perform any additional or expanded dental services that the dentist determines to be necessary. Further, at the dentist's discretion, I may be referred to a specialist for further treatment, the cost of which will be my responsibility.

Personal Information

It is our office policy to require personal information from our patients, including but not limited to social security number, date of birth, and a copy of a photo ID. Not providing this information could lead to refusal of treatment from our office. In the event a patient requests any of their information to be emailed, we will need the patient to first email us at the provided office email in order to verify the identity and satisfy HIPAA requirements.

***There will be a signed copy of this retained in your record.**

My Insurance covers this…right?

- Most benefit plans are only designed to cover a *portion* of the total cost.
- Typically there is always a portion that is **not** covered by your benefit plan.
- Some plans require that the network dentists observe restrictions to treatment. Many are not comfortable with this.

  Because your insurance is between **you, your employer, and the insurance carrier** your dentist does not have the power to make your plan pay. If your carrier does not pay, *you* are responsible for the total cost of treatment.

  Please keep in mind:

  - You have a **maximum** amount allowed for each insurance year (whether it is calendar year or not depends on your insurance plan) and you are responsible for knowing what that amount is and what is covered under it.
  - We have no control over your insurance company, and if they reject payment for any procedure, you must follow up and find out why.
  - As stated in the office's new patient papers you have signed, any treatment estimate we give is **an estimate**. We do our best; with the information we have from you and your insurance company, to provide you with the most accurate cost to you.

Ronald Fuhrmann DDS
a division of Atlantic Dental Care PLC

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 also 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 the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatments, payment or healthcare 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. You revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.
To your family and friends: W 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 you healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or 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 emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing 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.
Market Health-Related Services: We will not use your health information for marketing communications without your written authorizations.
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 a 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 authorize 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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably 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 cost-based 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 the Notice. If you request copies, we will charge $_0_ for each page and $_0_ 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 that 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 the 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 purposed, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

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 to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about 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 you 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 my deny your request under certain circumstances.

Electronic Notice: If you receive the Notice on our web site or by electronic mail (e-mail_, you are 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, or 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.

Contact Officer: Donna Fuhrmann – Office Manager

Telephone: 757-499-8465 Fax: 757-499-7624

Email: ronald.fuhrmann@yahoo.com

Address: 216 Business Park Drive, Suite A

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