Parkway Oral Surgery & Dental Implant Center Financial Policy

Thank you for choosing us as your health care provider for your surgical needs. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service is rendered unless other arrangements have been made in advance. The fees in our office are based on the care, skill, time, and judgment necessary to help treat your condition. The fee(s) for
your particular treatment will be discussed, and a detailed estimate shall be provided to you prior to any treatment.

The following is a detailed description of our financial policy :

- We reserve the right to collect payment before services are rendered.
- We accept cash, Visa, Mastercard, Discover, and American Express.
- We will be happy to assist you with applying for financing, should you so desire, with companies who specialize in healthcare
  financing for patient treatments.
- **The company we recommend is Care Credit**
    - Care Credit is our preferred medical and dental financing company. Please inquire with one of our treatment
      coordinators for more details.
- **Please remember that you are fully responsible for all fees charged by the office regardless of your insurance coverage.**
- Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your
  insurance coverage.
    - Insurance benefits are not guaranteed, we try our hardest to provide an accurate estimate of what your out of pocket
      portion will be however there are times that the insurance company will change their decision without our knowledge and deny coverage for procedures without our knowledge. If this were to occur, you are still responsible for any balance on your account. We will do all we can to help in getting you the benefits you deserve.

Fees for non-covered services, deductibles, and co-payments are **due at the time of treatment**.

- Because insurance policies vary greatly, we can only estimate your coverage and cannot guarantee coverage due to the
  complexities of insurance contracts.
- Your estimate portion must be paid at the time of service.
- As assistance to our patients, we will bill insurance companies for services rendered and allow them 45 days to remit payment.
- If your insurance company does not pay your claim within 60 days, you are expected to pay the entire balance due.
- If the balance is not paid after 60 days, interest will be automatically charged at a rate of 20% APR.

We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak to us if you encounter such problems, so that we may assist you in the management of your account. We appreciate your trust and the opportunity to serve you. Our patients are very important to us. If you have questions or need assistance regarding your account, please contact us at 713-467-5655. Our courteous staff is always available to help answer them or provide further clarification.

I have read the above conditions of payment and agree to their content. I grant my permission to you and your assignee, to telephone

me at home or at my place of work to discuss matters regarding this form. I authorize and request my insurance company to pay directly to Parkway Oral Surgery and Dental Implant Center otherwise payable to me. I agree to be responsible for payment of all services rendered on behalf of my dependents.

_____ _____

Patient / Parent/ Guardian-Printed Name Date

_____ _____

Patient/ Parent . Guardian-Signature Date

NOTICE OF PRIVACY PRACTICES

Parkway Oral Surgery and Dental Implant Center

Effective Date: 2/1/2015

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the privacy of your medical and dental information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This Notice describes your rights and our legal duties regarding your Protected Health Information ("PHI"). "Protected Health Information" means any information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this Notice, we call that protected information, "Medical and dental information". If you have any questions about this notice, please contact the HIPPA Officer for «Parkway Oral Surgery and Dental Implant Center ».

How Parkway Oral Surgery and Dental Implant Center MAY USE OR DISCLOSE YOUR MEDICAL AND DENTAL INFORMATION

1. Treatment. We will use your medical and dental information to treat you. For example, we may disclose your medical and dental information to other doctors, nurses, technicians, medical and dental students, or other members of our staff who are involved in taking care of you or to other care professionals for additional treatment or follow up care such as home health services. We also may disclose your medical and dental information to people outside of Parkway Oral Surgery and Dental Implant Center who may be involved in your care such as your family members.

2. Payment. We may use and disclose your medical and dental information to receive payment for our services from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure we perform at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3. For Health Care Operations. We may use and disclose your medical and dental information to operate Parkway Oral Surgery and Dental Implant Center. For example, we may use this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also share your medical and dental information with our business associates, such as a computer consulting service, that perform administrative services for us. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical and dental information.

4. Appointment Reminders. We may use and disclose your medical and dental information to remind you about appointments. If time allows, we will mail a postcard reminder. Otherwise, we may phone your home. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose your medical and dental information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your medical and dental information to notify or assist in notifying a family member, or another person who is involved in your care unless you ask us not to. In the event of a disaster, we may disclose information to a relief organization, such as the Red Cross, so that they may coordinate these notification efforts. We may also disclose information to someone who pays for your care. If you are unable to agree or object to these disclosures, our health professionals will use their best judgment in communicating with your family and others.

7. With Your Authorization. We may disclose your medical and dental information for purposes not described in this Notice or otherwise permitted by law only with your written authorization. You may revoke an authorization at any time, in writing, but only as to future uses or disclosures, and only where we have not already acted in reliance on your authorization. Revocations should be delivered to your Privacy Officer.

8. Required by Law. We may use and disclose your medical and dental information when required to do so by law, but only to the extent and under the circumstances provided in that law.

9. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your medical and dental information in response to a court or administrative order. We may also disclose medical and dental information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

10. Public Health and Safety. Your medical and dental information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities prevent or control disease, injury, or disability; to report birth defects or infant eye infections; to report cancer diagnoses and tumors; to report child abuse or neglect or a child born with alcohol or other substances in its system; to report reactions to medications or problems with products; to notify you of recalls of products you may be using; to notify the State Department of Health that a person may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition such as mv, Syphilis, or other sexually transmitted diseases; or to notify the appropriate governmental authority if we believe a patient has been the victim of abuse, neglect, or domestic violence, if the victim agrees to our reporting or if we are required to do so by law. Your medical and dental

information may be disclosed to appropriate persons in order to prevent or lessen a serious and imminent threat to you or to the health and safety of a particular person or the general public.

11. Specialized Government Functions. We may disclose your medical and dental information for military or national security purposes, national intelligence, protection of the President, or to correctional institutions or law enforcement officers that have you in their lawful custody.

12. Military. If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

13. Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. These oversight activities include, for example, audits, investigations, inspections, medical and dental device reporting and licensure.

14. Coroners/Funeral Directors. We may disclose your medical and dental information to coroners in connection with their investigations of death or to funeral directors to enable them to carry out their lawful duties.

15. Organ or Tissue Donation. We may disclose your medical and dental information to organizations involved in procuring, banking or transplanting organs, eyes and tissues, as necessary to facilitate organ or eyes donation or transplantation.

16. Workers' Compensation. Your medical and dental information may be used or disclosed as required by law related to workers' compensation.

17. Change of Ownership. In the event that Parkway Oral Surgery and Dental Implant Center is sold or merged with another organization, your medical and dental information will become the property of the new owner who will have access to it, although you will maintain the right to request that copies of your medical and dental information be transferred to another physician or Oral & Maxillofacial Surgery Practice.

18. Law Enforcement. Your medical and dental information may be disclosed to law enforcement authorities to identify or locate suspects, fugitives, witnesses, or victims of crime (with your consent in some circumstances) and to report possible deaths caused by criminal activities or to report crimes on the premises.

19. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical and dental information for marketing purposes without your written authorization.

20. Research. We may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information and has approved the research.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.

YOUR MEDICAL AND DENTAL INFORMATION RIGHTS

You have the right:

1. To receive a paper copy of this *Notice of Privacy Practices*.

2. To request restrictions on certain uses and disclosures of your medical and dental information by written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision. If we agree to a restriction, we may disregard it if the information is needed to provide you emergency treatment.

3. To request that you receive medical and dental information in a specific way or at a specific location. For example, you may ask that we send information to your work address. We will comply with all reasonable requests submitted.

4. To review and obtain a copy of your medical and dental information, with limited exceptions defined by law. A reasonable fee may be charged for making copies. Under State law, a fee of $1.00 for the first page and 50 cents for each page thereafter is allowed. If you request a copy of a film, you will be charged the actual cost of reproduction. We may also charge for postage if the copies are to be mailed. If we deny your request for copies, you will be informed of your rights to appeal our decision.

5. To request that we amend your medical and dental information that you believe is incorrect or incomplete. Your request to amend must be in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your medical and dental information and will provide you with information about Parkway Oral Surgery and Dental Implant Center 's denial and how you can disagree with the denial. Even if we accept your request, we may not delete any information already in your medical and dental record. You also have the right to request that we add to your record a statement of up to two hundred and fifty (250) words concerning any statement or item you believe to be incomplete or incorrect

6. To receive an accounting of disclosures made of your medical and dental information by this Parkway Oral Surgery and Dental Implant Center unless the disclosures were for purposes of treatment, payment, health care operations, certain government functions, or pursuant to your written authorization.

Contact:
If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact your Privacy Officer listed on the first page of this *Notice of Privacy Practices*.
Changes to this Notice:
We reserve the right to change or amend this *Notice of Privacy Practices* at any time in the future. After an amendment is made, the revised *Notice of Privacy Practices* will apply to all protected health information that we maintain. A copy of any revised *Notice of Privacy Practices* will be made available to you at each appointment.
Complaints about this *Notice of Privacy Practices*:
To file a complaint on how Parkway Oral Surgery and Dental Implant Center handles your medical and dental information should be directed to the attention of our Privacy Officer at Parkway Oral Surgery and Dental Implant Center. There will be no retaliation for filing a complaint. You may also submit a complaint to the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Patient Printed Name: _____

Patient/Guardian Signature: _____

Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT

Parkway Oral Surgery and Dental Implant Center and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by Parkway Oral Surgery and Dental Implant Center and are accessible to its personnel and medical staff for use in my care. Parkway Oral Surgery and Dental Implant Center personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Parkway Oral Surgery and Dental Implant Center is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Parkway Oral Surgery and Dental Implant Center charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Texas law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to Parkway Oral Surgery and Dental Implant Center, except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for Parkway Oral Surgery and Dental Implant Center charges payable to the insured are to be made payable to Parkway Oral Surgery and Dental Implant Center and that insurance benefits for services provided by physicians in the practice setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

You understand that Parkway Oral Surgery and Dental Implant Center will assist with insurance precertification requirements which are the responsibility of the policyholder and/or practice but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by Parkway Oral Surgery and Dental Implant Center charges for services and goods shall be at Parkway Oral Surgery and Dental Implant Center billed charges rates unless otherwise agreed to in writing by Parkway Oral Surgery and Dental Implant Center.

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect has an original

_____ _____

Name of Patient/Patient's Legally Authorized Representative Date

_____ _____

Signature of Patient/Patient's Legally Authorized Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Parkway Oral Surgery and Dental Implant Center is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment. The Notice is posted throughout our office and you will be given a copy for your personal use. A copy of Parkway Oral Surgery and Dental Implant Center's Notice of Privacy Practices was provided to you.

_____ _____

Name of Patient/Patient's Legally Authorized Representative Date

_____ _____

Signature of Patient/Patient's Legally Authorized Representative Date

Parkway Oral Surgery
Appointment No Show/Cancellation Policy

As a dental specialty surgical center, our day is carefully scheduled with every effort given to proper time allotments for individualized care of each of our patients. Preparation procedures including supplies, equipment and staffing can be extensive and costly. When an appointment is scheduled, that time has been set aside for you and when it is missed or rescheduled with late notice, that time cannot be used to treat another patient. We have therefore implemented the following policies regarding no shows and cancelled appointments.

Our policy is as follows

- **A minimum of 48 hours' notice is required for all surgery cancellations.** Cancellations for Monday appointments are required by 1:00 p.m. on the previous Thursday. Cancellations for Tuesday appointments are required by 1:00 p.m. on the previous Friday.

Our policies and procedures have been established to ensure the highest quality of care. No shows and late cancellations prevent others in the community from receiving much needed specialty care.

Thank you for your understanding and adherence to this policy.

Patient: _____ **Date:** _____

Social Media Release Form for Parkway Oral Surgery

I, _____, **DO / DO NOT** (circle one) authorize Parkway Oral Surgery and Dental Implant Center to use photos or videos of me on their social media tools which includes, but is no limited to, their Facebook page, Instagram and/or Snapchat, website, and other Parkway specific marketing programs. I understand that these images and/or videos will not be used for any other commercial purposes.

Images and videos will be related to oral surgical procedures. Video testimonials may show my face and voice unless I specifically request anonymity. Surgical photos and videos will not show my facial features in order to protect my identity.

Patient Signature: _____

Parent/Guardian Signature: _____

Date: _____