DR.FITZSIMMONS
1730 E. Main St.
Newark, Ohio 43055

Our goal at Thomas Fitzsimmons DDS is to provide quality dental care in a timely manner. We do understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 24 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting. We appreciate your understanding and consideration regarding our cancellation and failed appointment policy.

· Cancellation or rescheduling of an appointment with 48 hours or more notification will result in no charge.

· A failed appointment is an appointment that is cancelled/rescheduled without 24 hours' notice or an appointment where a patient does not show up.

· We do allow for one (1) broken appointment as a courtesy.

· Any additional failed appointments will be charged a fee of $40 for a hygiene appointment and/or $75 per hour for a doctor's appointment.

· After two (2) failed appointments we may require a deposit of up to 100% that will be applied to your appointment, in order to reserve any further appointments.

· After three (3) failed appointments you risk being dismissed from the practice. To cancel appointments please call 740-763-3926. If you do not reach the scheduling coordinator you may leave a detailed message on the voice mail. You may also cancel your appointment using the confirmation text that is sent to you from Thomas Fitzsimmons DDS through our patient communication system, Lighthouse.

_____ _____

Patient signature Date

Thomas Fitzsimmons, DDS

1730 E MAIN STREET | NEWARK OH, 43055 | (740) 763-3926

Written Financial Policy

Thank you for choosing Thomas Fitzsimmons DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash or check, Visa®, MasterCard® or Discover Card®

- Special financing options with convenient monthly payments available with the CareCredit, a healthcare credit card[1]

o Allow you to pay over time

- No annual fee[3]

Please note:

If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Thomas Fitzsimmons DDS charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____

Patient, Parent or Guardian Signature **Date**

_____

Patient Name (Please Print)

[1]CareCredit is a credit card offered by Synchrony Bank and is NOT an in-house credit program offered by Thomas Fitzsimmons DDS or any other healthcare provider. You may apply for the CareCredit healthcare credit card and if approved, use it at Thomas Fitzsimmons DDS's office. However the CareCredit credit card agreement is between you and Synchrony Bank. Subject to credit approval. [2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. [3]For new accounts: Purchase APR is 26.99%; Minimum Interest Charge is $2. Existing cardholders should see their credit card agreements for their applicable terms. Subject to credit approval.

To My Appreciated Patient,

This year marks the beginning of many exciting changes in my office, in my effort to improve service and quality of care for you that you can regain and maintain your health quickly, efficiently, and inexpensively as possible.

I have a purpose, and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you.

Therefore the following policies must be agreed upon:

Visits: Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves. We request that you brush your teeth prior to being seated in a treatment room. Toothbrushes, paste, mouth rinse and floss will be provided for you if needed.

Insurance: Treatment recommendations are based on your health not your insurance or lack thereof. If you have insurance it is **your** responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being, WE ARE! We will provide you with an estimate of benefits; however, you are fully responsible for any treatment performed. **Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will/will not cover**.

Financial: **We run a Zero Balance office. We expect payment in full prior to or at the time treatment is provided**. We have several financial options available for all of our patients. Please speak to Rickell at the front desk if you have any questions.

Motto: Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.

Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have, by providing care for you, before it becomes a problem. In the rare instance that you do have a dental emergency, we want you to be assured that we will take care of you. In order to do this, we would like to define what a true emergency is; Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in visible areas are considered emergencies. If you have any of these symptoms, we ask that you call us right away. (740.763.3926) We will provide you with the next emergency appointment. We do set time aside each day for emergencies.

Timeliness: **Timeliness is required**. We will see you on time and get you out on time, unless there is an emergency. We request that you be on time for your visits. **If you are more than 10 minutes late, you may have to reschedule your appointment**.

Broken Appointments: **No-Shows are not acceptable**. Failure to make a scheduled appointment not only compromises your health, but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make your scheduled appointment time (except in case of an emergency) you are expected to call the office within 48 hours of your appointment time to reschedule. **Failure to do so may result in a fee.**

I greatly appreciate your cooperation.

Yours in Health,

Dr. Thomas M. Fitzsimmons

_____ _____

(Patient Signature) **(Date)**

Thomas M. Fitzsimmons

1730 E. Main St Newark, OH 43055

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Please Print

_____ _____ _____

(Last Name) **(First Name)** **(Middle Initial)**

Do We have permission to?

Send a recall appointment reminder to your home? Y_____N_____

Leave the following information on your home answering machine/cell voice mail?

Appointment Information Y_____N_____ Billing Information Y_____N_____ Dental/Medical Information Y_____N_____

Leave the following information on your work answering machine/voice mail?

Appointment Information Y_____N_____ Billing Information Y_____N_____ Dental/Medical Information Y_____N_____

I give permission to share appointment information with the person(s) named below:

Name(s):_____

I give permission to share billing information with the person(s) named below:

Name(s):_____

I give permission to share dental/medical information with the person(s) named below:

Name(s):_____

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date

_____ _____

Signature of Patient/Parent or Legal Guardian **Date**

Privacy Policy/HIPPA Compliance

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

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for such health care.

We use and disclose PHI about you for treatment, payment and health care operations

Treatment:

We may disclose PHI for your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment:

We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations:

We disclose your PHI as part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any situation, we will ask for your written authorization before using or disclosing your PHI. If you chose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations.)

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights:

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than the treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U. S. Department of Health & Human Services. Customer service can provide you with the appropriate address upon request.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office at 740-763-3926.