OFFICE PROCEDURES
FRANK HERNANDEZ D.D.S. INDIO, CA

1. **PHONE CONFIRMATIONS: IT IS OUR OFFICE POLICY THAT YOU CALL 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT OR THER WILL BE A CHARGE OF $20.00. IF YOU HAVE AN HOURLY APPOINTMENT YOU MUST CALL 72 HOURS IN ADVANCE OR THERE WILL BE A CHARGE OF $70.00.**

2. **VERBAL AUTHORIZATION: IT IS OUR OFFICE POLICY TO GET VERBAL AUTHORIZATION FROM ALL NEW PATIENTS TO CONFIRM APPOINTMENTS AND LEAVE MESSAGES IF PATIENT IS NOT AVAILABLE. ALSO PATIENT MUST CALL 24 HOURS IN ADVANCE TO CANEL APPOINTMENTS. IT IS ALSO OUR PROCEDURE THAT WE GET YOUR INSURANCE INFORMATION SO WE CAN CONFIRM THAT STATUS OF YOUR INSURANCE AND GET PRIOR AUTHORIZATION FOR TREATMENT AS NEEDED.**

3. **IT IS OUR OFFICE POLICY THAT WE MAIL REMINDER POSTCARDS THAT SAY "IT'S TIME FOR YOUR DENTAL CHECK-UP YOUR APPOINTMENT IS"….**

4. **I AUTHORIZE THE FOLLOWING PERSON(S) TO BE MY PERSONAL REPRESENTATIVE, WHICH MEANS THE DOCTOR AND STAFF MAY SPEAK FREELY TO THE NAMED PERSON(S) REGARDING ALL MY PROTECTED HEALTH INFORMATION: MEDICAL, TREATMENT MATTERS AND BILLING.**

NAME **RELATIONSHIP**

_____**SPOUSE**_____
_____
_____

_____
PATIENT'S SIGNATURE **DATE**

5. **I AUTHORIZE THE FOLLOWING NAMED PERSON(S) TO AUTHORIZE MEDICAL TREATMENT FOR MY NAMED CHILDREN. THE DOCTOR AND STAFF MAY SPEAK FREELY REGARDING MY CHILDRENS PROTECTED HEALTH INFORMATION, MEDICAL TREATMENT AND BILLING. I UNDERSTAND THAT I AM STILL RESPONSIBLE FOR THE BILLING.**

NAME OF AUTHORIZED PERSON/RELATIONSHIP **CHILDS NAME**

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PATIENT'S SIGNATURE **DATE**

6. **I _____AUTHORIZE FRANK A. HERNANDEZ D.D.S. TO EXAMINE AND PROVIDE MEDICAL TREATMENT. I ASSUME FULL RESPONSIBILTY FOR ANY BALANCE DUE. I AUTHORIZE MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT DIRECTLY TO FRANK A. HERNANDEZ D.D.S.. I AUTHORIZE FRANK A. HERNANDEZ D.D.S. TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS. I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW ALL RULES AND RESTRICTIONS OF MY INSURANCE POLICY TO KNOW WHICH HOSPITAL, EMERGENCY ROOMS, LABORATORIES, X-RAY DEPARTMENTS AND SPECIALISTS AND SPECIALTY PROVIDERS WHICH ARE ASSIGNED TO ME ACCORDING TO MY INSURANCE POLICY. IT IS FRANK HERNANDEZ D.D.S. OF INDIO, CA'S PROCEDURE TO SHARE PROTECTED HEALTH INFORMATION WITH LABS, X-RAYS, CONSULTING PHYSICIANS AND HOSPITALS. WE WILL CALL THE PHARMACY OF YOUR CHOICE REGARDING YOUR PRESCRIPTIONS. WE WILL ONLY EXCHANGE MINIMUM NECESSARY PROTECTED HEALTH INFORMATION FOR EACH TRANSACTION.**

7. **OUR OFFICE IS HIPPA COMPLIANT AND THE STAFF HAS BEEN TRAINED IN THE HIPPA PRIVACY ACT. WE WILL DO EVERYTHING WE CAN TO PROTECT YOUR PATIENT HEALTH INFORMATION.**

   HOWEVER, OUR OFFICE WAS DESIGNED BEFORE THE HIPPA LAW SO PLEASE BE RESPECTFUL OF OTHER PATIENT'S PRIVACY.

WE BILL YOUR INSURANCE AS A COURTESY, INSURANCE COVERAGE IS ESTIMATED. YOU THE PATIENT ARE RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY YOUR INSURANCE CARRIER.

FINANCE CHARGES START ACCRUING AFTER 30 DAYS ON UNPAID BALANCE. THE FINANCE CHARGE IS 14%.

I,_____AGREE TO ALL OF THE ABOVE OFFICE POLICIES OF FRANK A. HERNANDEZ D.D.S. OF INDIO, CA. AND GIVE MY AUTHORIZATION TO ALL OF THE ABOVE PROCEDURES.

PATIENT:_____

DATE:_____

LIST NAMES OF MINOR FAMILY MEMBERS AND THEIR AGES

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_____ **SPOUSE**_____