HIPAA NOTICE OF PRIVACY PRACTICES

FIESTA DENTAL CARE
3165 S. ALMA SCHOOL RD #26
CHANDLER AZ. 85248
(480) 726-0360

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is

ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164,500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: Information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

OFFICE GUIDELINES
FIESTA DENTAL CARE

We realize that every person's financial situation is different. For this reason, we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

CONSENT

I authorize the doctor to obtain x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before treatment is begun.

If care is being rendered on a minor child, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for payment.

FINANCIAL RESPONSIBILITY

1. Balances remaining beyond (30) days from first billing will accrue interest at a rate of 1.5% per month on the unpaid balance. (18% Annual rate)
2. There is a $25 charge for all returned checks.
3. Personal credit may be checked.
4. In the event of default, I promise to pay legal interest on the indebtedness, collection cost, and related attorneys' fees.

DENTAL INSURANCE

We are happy to file forms necessary to see that you receive the full benefits of your coverage. However, we cannot guarantee any estimated coverage. Unless prior arrangements are made, you will be expected to pay your portion as services are provided. Please keep in mind that we can only estimate your portion. If there is a difference after your insurance has paid, it is your responsibility to pay that difference. Because the insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over your claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits. Any balances not paid by the insurance company within 60 days of submission becomes the patient's responsibility to pay.

PAYMENT OPTIONS

Cash or check: We are able to offer a 5% pre-payment courtesy for treatment that exceeds $100.00 and paid in full at the time of treatment.

Credit Card: For your convenience, we have made arrangements to accept payment by several major credit cards as well as bank debit cards.

Payment Plan: For patients who desire a monthly payment plan, we offer a three, six or twelve month interest free financing through American General. Applications are available from our financial coordinator and can be processed quickly.

Optional Payment Plan: You may divide half of your payment at the start of treatment and the balance upon completion.

My signature will authorize assignment of insurance benefits to this office.

_____	_____	_____
Patient's signature Or Parent/Legal guardian	Printed name	Date