Dr. Anaheata Esmailzada
Montville Smiles
350 Main Road suite 202
Montville NJ 07045

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given under the Health Insurance Policy Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the office to use my protected health information to carry out:

- Treatment
  (Including Direct and Indirect treatment by another healthcare provider involved in my treatment)
- Obtaining payment from third party payers (Example, my insurance company);
- The day-to-day healthcare operation of your practice

Also, I have been informed and given right to review and secure a copy of the office's *Notice Of Privacy Practices.* This notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that the office reserves the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected

Print Patient Name _____

Signature _____

Date _____

Relationship to Patient _____

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CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to Montville Smiles to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Montville Smiles . I understand that, for security purposes, the site requires a user ID and password for access and use.

I also understand Montville Smiles and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Montville Smiles is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality.

I understand Montville Smiles is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Montville Smiles web site with my ID and password.

I also agree to immediately notify Montville Smiles of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties.

I understand Montville Smiles will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws.

I agree that Montville Smiles has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Montville Smiles will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf.

I understand Montville Smiles CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for Montville Smiles, and grant Montville Smiles permission to securely upload my patient information to the web site.

Date_____

Print Patient Name _____

Signature _____

Relationship to Patient _____

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OUR PATIENT CANCELLATION POLICY

We would like to take this opportunity to thank you for coming to our office. Our goal is to provide optimal dental health to all our patients. Accordingly, we will schedule any appointments in a timely manner. We are conscientious that everyone has a busy schedule and sometimes it may be necessary for patients to cancel an appointment. If this is the case, we ask that you give the office at least 24 hours notice. If notice is given within less than 24 hours, our office will try to fill your space, but if we are unable to do so we will bill you for lost time.

Please read and sign the policy below

Cancellations ARE REQUIRED WITHIN 24 HOURS NOTICE

- In the case of the first missed appointment: patients will receive a phone call informing them of their missed appointment
- By the second missed appointment: patients will be charged a $50.00 fee, which is NOT covered by the insurance
- The third missed appointment: patients will be charged the $50.00 missed appointment fee again
- Further missed appointments will result in dismissal from our office

Patient Name _____ Patient Signature_____

Date _____