



135 Warren Ave. Pocatello, ID 83201 phone: 208.237.6453 fax: 208.233.4227

HIPAA

- We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may compromise the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you do change your mind.
- For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of this notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. *Effective: 07/01/2017*

This Notice of Privacy Practices applies to the following organization.

Oak Mountain Dental
Dr. Jake R. Richards DDS, PLLC
Dr. Mitch J. Driscoll, DMD
Dr. Brandon Call DDS

I, _____, acknowledge that I have had the opportunity to read, and request a copy of, the current Oak Mountain Dental, Notice of Privacy Practices.

Signed _____ Date _____

Patient Name (please print)

***Please print – all persons who can receive private information on this patient's behalf.**



135 Warren Ave. Pocatello, ID 83201 phone: 208.237.2453 fax: 208.233.4227

Financial Information

Deductibles, co-payments, and any portion not covered by your insurance is due at the time of your visit.

We accept cash, personal checks, Visa, Mastercard, Discover, AMEX, and Care Credit. If you are unable to pay in full at the time of your visit, please speak with a receptionist prior to your treatment. · A \$25 fee will be charged to the account for all returned checks.

· A \$10 fee will be charged to the account for declined credit cards.

Insurance: I request and authorize insurance benefits to be paid directly to the dentist. I also authorize the release of the information, by the dentist and my insurance company, necessary to process my claims, or collect payment. **I understand that I am fully responsible for any balance. Any estimates given are not a guarantee of payment by my insurance.** Oak Mountain Dental will bill your insurance as a courtesy. **It is your responsibility to know your insurance coverage and limitations.** Our front office staff will be happy to help you acquire needed information. I have read and understand all stated financial policies of the office.

Patient/Guardian Signature _____ Date _____

Appointment Policy

Broken Appointments:

Your appointment is time that has been reserved especially for you, by you and we request that all patients keep and be on time for their appointments. If you must change your appointment, we require at least 24 hours' notice to avoid a possible **\$75.00** cancellation fee for an appointment cancelled without the requested notice. We reserve the right to refuse treatment and/or dismiss any patient that fails to comply with the above appointment policy.

Patient/Guardian Signature _____ Date _____

This document is maintained by the Privacy Officer of Oak Mountain Dental: Pablo Morfin. Phone (208) 237-6453. She can also be reached at: admin@oakmountaindental.com