Eric and Casey Burns, DDS
4914 Randall Parkway
Wilmington, NC 28403
910-799-9059

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have read and been offered a copy of **Eric and Casey Burns, DDS** Notice of Privacy.

__________________________ Patient Name

__________________________ Date of Birth

__________________________ Signature of Patient

__________________________ Date

Emergency Contact Information

Name: ____ **Relationship to Patient:** ___________________________

Phone: ____ **Address**: ____

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Eric and Casey Burns DDS is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity approved To receive information	**Description of information to be released** Check items that may be provided the person/entity on the left	
Voice Mail	Results of lab tests/x-rays	
Employer/School	Appointment absentee information	
Spouse (provide name)	Financial	
	Medical	
Parent (provide name)	Financial	
	Medical	
Other (provide name)	Financial	
	Medical	
Support Group (provide name)	Demographic Information	

Rights of the Patient: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Eric and Casey Burns DDS**.I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. Written notification will be sent via first class mail for any breach involving over 500 patients per HIPAA regulations.

________________________________ Signature of Patient

___________________________ Date

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Office Policies

Appointments: Patients are seen by appointment. For urgent situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem so that scheduled patients are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients.
We work very hard to keep our appointment schedule; however, because we see emergencies in the office, there may inevitably be delays. We apologize in advance and will make you aware at your appointment if we are behind, at which point you may choose to reschedule.
We make every effort to confirm your appointment at least two days in advance via phone, email or text based on your preference. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment**. Cancellations must be made 48 hours** prior to your appointment.

Social Security Numbers: We handle patient's social security numbers and personal information in a confidential manner but we may release personal/medical information to another doctor's office in the event of a referral. We use social security numbers for strictly insurance and billing purposes and it is required from each of our patients.

Insurance: Insurance is a contract between you and your insurance company. We are not actually involved in that contract; therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles or benefit amounts. Currently we file claims for all **primary** insurance plans, secondary insurance is the patient's responsibility. Our system calculates estimated insurance benefits based on the information supplied to us, it is however, only an **estimate** of coverage. If you wish to know the exact amount your insurance will cover, contact your insurance company with the service codes supplied via your treatment plan. Also, if your carrier changes, it is your responsibility to inform us of this prior to your appointment.

Payment: Payment is due from each patient at the time of service. We accept cash, check, Visa and MasterCard. Patients with deductibles, percentage fees, etc. are expected to pay at the time of their appointment. Simply stated, payment of any portion of your bill that you are responsible for "out of pocket" is expected at the time of your appointment. A $35.00 service fee will be applied for all return checks.

Anesthetic Release: Generalized local anesthesia is used when treatment is rendered to minimize pain and provide our patients with the most comfortable dental experience possible. Although the risk is small, local anesthesia can cause temporary or permanent paralysis in the mouth region, including jaw and tongue.

Minors: A parent or guardian must accompany all children under the age of 18. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

Cancellations: Cancellations must be made 48 hours prior to your appointment to allow adequate time to fill your reserved time slot. If less than 48 hour notification is provided, your account may be subject to a $25 fee based on the Drs. discretion. Our practice voicemail/email does not accept cancellations or appointment changes – please contact our office during normal business hours for any requested appointment changes.