Captivating Smiles, LLC
LeToiya Carter-Robinson, DDS
2118D Scenic Hwy, Snellville GA 30078
Ph: 770-609-2901 Fax: 770-609-2904 Email: lcrobinson@captivatingsmilesatl.com

Office Policy

High quality care and **patient comfort** are our highest mission. We pledge to provide the finest personal service for our patients who will always enjoy a warm, relaxed and comfortable environment. Within these walls dwell people dedicated to the complete wellness of each person who enters. By reaching out to people through ourselves, we can give them the understanding, compassions, and quality care they deserve.

Confirmation Policy

If our office is unable to confirm your dental appointment verbally with you, we do reserve the right to cancel your appointment and reappoint to another patient. Please be sure to keep us in mind when you change your phone, work or cellular phone numbers to avoid this situation.

Appointment Policy

We reserve our time, facilities and equipment especially for you to receive high quality dental care. To keep our fees from rising, we politely request at least a **48 hour** notice if you are unable to keep a reserved appointment. Without this notice we reserve the right to charge a **$30 broken appointment fee**. After **three missed or broken appointments** per family we reserve the right to politely ask your family to receive dental care at another office. If you are a new patient to our office, we will only allow you to miss or break your appointment with our office only once. After that, we will be unable to provide dental care to you or your family members. We ask that you please try to understand our position on this delicate situation and kindly confirm your reserved appointment with our office no later than **48 hours** before your appointment time.

Payment Policy

Payment is required in full **at time services are rendered**. We accept cash, personal checks, Visa, Discover, MasterCard, American Express, and money orders. We except most insurance plans, keeping in mind that your patient portion is also due **at the time services are rendered**. All returned checks are subject to a **$35.00** NSF fee, which will also remove all of your check writing privileges to our facility. As a courtesy for services prior to treatment, we are willing to provide financial options where they are available. Please inquire with our finance department.

Late Arrivals

We attempt to schedule our patients as efficiently as possible to reduce your wait time in our reception area. Due to this method of scheduling, it is imperative that we are able to start your appointment at the time we have scheduled for you. If you arrive for your appointment more than 10 minutes late, we do reserve the right to reschedule your appointment for another day. With this policy in mind, if our office runs behind for your appointment more than 10 minutes, we will allow you to reschedule your appointment with no penalty to your record.

I, the undersigned, assign Dr. LeToiya Carter-Robinson all dental benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of my Dental Benefits. I understand that any dental claims outstanding with my insurance company for more than 90 days will be assessed a 15% finance charge and will become my financial responsibility. I hereby authorize the use of all information necessary to secure payment of benefits, either by manual or electronic filing.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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**.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
_ **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.

_ **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.

_ **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.
In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment alternatives or other health-related services. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

_ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

_ The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
_ The right to access, inspect and copy your protected health information.
_ The right to request an amendment to your protected health information.
_ The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
_ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.
For more information about our Privacy Practices, please call our office or visit the office contact person, at the address shown at the beginning of this Notice.

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ACKNOWLEDGEMENTOF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:
_ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
_ Obtain payment from third-party payers for my health care services
_ Conduct normal health care operations such as quality assessment and improvement activities
I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
Patient Name: ___________________________________ Date: __________________________
Signature: _______________________________________ Provider/Practice Name:
Relationship to Patient: ___________________________ **LeToiya Carter-Robinson D.D.S. / Captivating Smiles, LLC**
Dependent family members also covered by this acknowledgement:

I have been informed of your revised *Notice of Privacy Practices* on the following date(s):
Date: ________________
Signature:____
Date:________________
Signature:____
Date:________________
Signature:____

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For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:
___ The patient refused to sign ____ Communication barriers____ Emergency situation ____Other

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Welcome Letter To Patients and Thank You to Our Patients

We would like to take this opportunity to welcome and thank you for choosing our office for your family's dental health care needs. At Captivating Smiles, we strive to give our patients the best dental care possible in a relaxing and friendly atmosphere.

We take pride in our modern facility and offer the latest in dental technology and medical safety precautions. Our dental team is highly trained and will provide excellent care for you at each and every appointment.

Your first dental appointment will be with Dr. LeToiya Carter-Robinson and her Assistants. Your first visit will consist of a thorough Comprehensive Exam and Full Mouth Series of X-rays (if eligible) on all adult patients to detect tooth decay and tooth related illnesses. Your comprehensive exam will also include probing measurements, which help to determine your oral cleaning needs, as there are different types of cleaning treatments, Healthy Mouth Prophylaxis, Full Mouth Debridement, and Scaling and Root Planning (deep cleaning). We will explain your needed treatment as well as answer any questions you may have. Our front desk staff will make your follow-up appointment and give you a copy of your treatment plan before you leave the office.

Again, welcome to our office and we hope you enjoy your visit.

We Sincerely Thank You For Choosing Our Practice.

Signature:_____ Date:_____