Nouvelle Dentistry
8000 East Belleview Avenue, Suite E15
Greenwood Village, Colorado 80111
(303)770-8870

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ **Date of Birth :** _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

-A statement that this practice is required by law to maintain the privacy of protected health information.
-A statement that this practice is required to abide by the terms of the notice currently in effect.
-Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
-A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
-A description of uses and disclosures that are prohibited or materially limited by law. I description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
-My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- -The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- -The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- -The right to receive confidential communications of protected health information.
- -The right to inspect and copy protected health information.
- -The right to amend protected health information.
- -The right to receive an accounting of disclosures of protected health information
- -The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Nouvelle Dentistry
Office Policy Overview

Thank you for choosing Nouvelle Dentistry for your dental health provider.
It is our goal to provide you with the best care possible as well as exceed your expectations regarding the handling of your account. It is important that you understand our office policies. We are happy to answer any questions you may have regarding these policies at any time.

Cancellation Policy

- If you need to cancel or change your appointment, we request a 72 hour notification; however, a 48 hour notice is required.
- Missed or cancelled appointments with less than a 48 hour notice will be assessed a minimum of a $45.00 cancellation fee.
- We reserve the right to discontinue patients who fail to follow our policies.

We realize there are times when you are unable to keep an appointment for various reasons outside your control. These occasions will be reviewed on an individual basis.

Financial Policy

If you do not have insurance: All payments are due and payable at the time services are rendered. Please feel free to contact us if you have questions about fees or payments.

Co-payment/Co-Insurance Policies: All co-payments are due and payable at the time of service. We will verify your insurance benefits to the best of our ability. Please, however, understand that this does not guarantee benefits. You, the patient, are ultimately financially responsible for the care you receive in this office. For your payments, we accept cash, check, or credit card. Any returned checks will be charged a $25.00 fee in addition to the amount of the check.

I certify that I have read and understand the information listed above. I authorize any of the doctors or dental auxiliaries to proceed with general dental treatments as necessary and explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of my appointments.

I understand that it is my responsibility to ask questions regarding these policies if my understanding is unclear.

Print Name: _____ Date: _____

Signature: _____