I understand and agree to the following:

1) I am responsible for any fees not paid by my insurance. Any fees quoted by us are estimates only and are subject to change.
2) Balances older than 60 days regardless of insurance benefits and returned checks will be subject to an interest charge of 1.5% per month.
3) I may be charged a $50 cancellation fee per hour for a broken appointment or short notice cancellations of less than 24 hours.
4) My health/dental history may be shared with other medical or dental professionals during the course of my dental treatment.
5) I have reviewed or have access to the Dental Materials Fact Sheet which describes common dental materials that any dental office may use (see below) as required by California Law.
6) The office may contact me by phone regarding appointments and financial matters.

The full HIPPA Policy/Financial Policy/Dental Materials Facts Sheet are available online at www.mountainandseadental.com. This is also available on paper by request (called: HIPPA, Financial Policy & DMFS).

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

Mountain and Sea Dental and Associates

FINANCIAL POLICY
NOTICE OF PRIVACY PRACTICES
AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION
DENTAL MATERIALS FACT SHEET RECEIPT ACKNOWLEDGEMENT

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. Our practice depends upon reimbursement from our patients for the costs incurred for their care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. There is a $50 cancellation fee per hour for a broken appointment or a short-notice cancellation of less than 24 hours.

Payment for services is due at the time services are rendered (including insured person's portion) unless payment arrangements have been approved in advance by our business staff. For your convenience, we accept cash, checks, Visa, American Express or Mastercard. We also have a no-interest or a low-interest financing plan though a private credit company. We are happy to help you process your insurance claim forms at no additional cost and will accept assignment of insurance benefits. However, we must have your completed insurance form and a provider benefit booklet at your first visit.

Balances older than 60 days regardless of insurance benefits and returned checks will be subject to an interest charge of 1.5% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We ask your understanding that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance as determined by each carrier. This applies only to companies who pay a percentage (Such as 50% or 80%) of "U.C.R," which means usual, customary and responsible by most companies. (NOTE: This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.)
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. With your benefit booklet, we can help you determine your benefits.
4. Our estimated fees for your treatment plan are estimates only. While this estimate will be accurate most of the time, during the course of treatment, fees may change due to additional or changes in treatment as well as changes in the estimated insurance fees or payments. Any balances remaining due to these changes are your responsibility.
We must emphasize that as dental care providers, our relationship is with you, our patient, and not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility from the date services are rendered. We realized that temporary financial issues may affect timely payment of your account. If such a problem should arise, we ask that you contact us immediately.
If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.
I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the above information and understand and agree to the content.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.The Dental Practice Covered By This Notice

This Notice describes the privacy practices of Mountain and Sea Dental and Associates "We" and "our" means the Dental Practice. "You" and "your" means our patient. **How to Contact Us/ Our Privacy Official**

If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice Name:	Mountain and Sea Dental and Associates
Privacy Official for Dental Practice:	Lenaya Andriulli
Dental Practice mailing address:	2780 State Street Suite 6 Santa Barbara, CA 93105
Dental Practice email address:	drcarleysreception@gmail.com
Dental Practice phone number:	805-681-4848

Information Covered By This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- maintain the privacy of your health information;
- give you this Notice of our legal duties and privacy practices with respect to that information; and
- abide by the terms of our Notice that is currently in effect.
- **Will allow you to receive ANY requested documents by contacting our office.**

Our Use and Disclose of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, text or email.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence. **Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes. We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation. We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes. We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety. We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions. We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation. We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access. You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised

Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information:

Dental Practice Name:	Mountain and Sea Dental and Associates
Privacy Official for Dental Practice:	Lenaya Andriulli
Dental Practice mailing address:	2780 State Street Suite 6 Santa Barbara, CA 93105
Dental Practice email address:	DrCarleysreception@gmail.com
Dental Practice phone number:	805-681-4848

Your contact information (You do not need to complete at this time)

Patient name:	
Patient mailing address:	
Patient email address: (Optional)	
Patient phone number:	

Protected Health Information that I am authorizing the Dental Practice to release:

I authorize the Dental Practice named above to release the following Protected Health Information:
___X All Dental report(s)
___X All Dental image(s)

___XAlldentalrecords
re_____

___ All dental records received or created by the Dental Practice between the following dates:

___ Other (specify) _____

Any of these reasons for the release of the Protected Health Information

___ Patient Request ___ Review Patient's current care___ Treatment/ continued care___ Payment for care, including insurance___ Legal___ Obtaining Social Security Disability or other public benefits ___ Other(specify):_____

If you want your Protected Health Information to be provided to the organization/person by email, please provide the email address:_____.
If you want your Protected Health Information to be provided to the organization/person by fax, please provide the fax number: _____.
When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization. If you sign this Authorization,.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____
Patient Signature Date

OR_____Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

A) Parent B)Guardian C)PowerofAttorney D) Other:_____

DENTAL MATERIALS FACT SHEET RECEIPT ACKNOWLEDGEMENT

The Dental Materials Fact Sheet is a booklet that describes the content, safety, and advantages/disadvantages of dental materials such as ones used in dental fillings and other restorative material. Some of the dental materials listed in the fact sheet may not be used in this office, such as amalgam. This fact sheet is available in this office for you to read or to obtain a copy of. Please request a copy of the fact sheet if you would like to keep.