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Office Policies

PATIENT RIGHTS

- Right to receive information necessary to give informed consent prior to the start of any procedure and/or treatment.
- Right to refuse treatment, provided that you are responsible for the consequences of the decision.
- Right to privacy concerning your dental care and expect that all communications and records pertaining to your care is treated as confidential.
- Right to receive an explanation of your bill regardless of the source of payment.

PATIENT RESPONSIBILITIES

- Provide us with all information needed in order to care for you, including accurate, current health history and medication list
- Provide accurate insurance information and accept the financial obligations (copayments and deductibles) associated with services rendered.

RESCHEDULING APPOINTMENTS:

- If you are unable to keep your scheduled appointment, please call our office at least **24 hours** before your appointment.

NO SHOWS

- If you are unable to keep your appointment and do not notify the office within 24 hours, you will be charged a **no-show fee of \$50**. If you cancel on the day of your appointment, the no-show fee will be assessed. This fee is not covered by insurance.
- Patients who consistently no-show, fail to cancel or reschedule their appointments will no longer be allowed to make appointments but instead will be seen on a walk-in basis. As a walk-in, there will be a wait to be seen.



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 PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by law to maintain the privacy of your health information. We are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2020, and will remain in effect until we replace it. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION If you give us an authorization, you may revoke it in writing at any time. We use and disclose health information about you for treatment and payment. For example:

- Treatment: To notify your physician or healthcare provider
 - o A consultation with your doctor may be needed if you have certain medical conditions prior to dental treatment
- Payment: To preauthorize or obtain payment for dental services
 - o We will send proposed or completed treatment information to your insurance company electronically or through the mail to bill for services on your behalf
- Dental Specialist: X-rays and treatment information may be sent electronically to a specialist as needed
 - o For example, sending X-rays to an oral surgeon if you are referred to them

Unless you give us a written authorization, we cannot use or disclose your health information for any reason except:

- *To Your Family and Friends:* We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment, but only if you agree that we may do so.
- *Persons Involved In Care:* We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- *Required by Law:* We may use or disclose your health information when we are required to do so by law.
- *Abuse or Neglect:* We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

RIGHT TO ACCESS YOUR RECORDS You have a right to access your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you \$0.25/page and \$15 for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

I have read and understood the above office policies.

Printed Name

Signature of patient or legal guardian

Date: