Maryam Nejat D.M.D

11701 Livingston Road, Suite 305
Fort Washington, MD. 20744
Phone: 301.292.0105 Fax: 301.292.5527

HIPAA ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR PATIENTS:

I have received a copy of Dr. Maryam Nejat's Privacy Practices, effective 01/01/2015. I also agree that the office Dr. Nejat may send emails, text messages and automated phone calls for the purpose of appointment confirmation and practice advertisements.

Patient Name: _____

Signature: _____ Date: _____

Printed Name: _____

FOR PARENTS OR LEGAL GUARDIANS:

I am a parent of legal guardian of _____. I have received a copy of Dr. Maryam Nejat's Notice of Privacy Practices effective 01/2015.

Name: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian

Signature: _____Date: _____

STAFF USE ONLY

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgement could not be obtained and the efforts that were made to obtain it.

- Notice of Privacy Practices, effective 01/2015 given to individual on _____.
  ☐ In person ☐ Mailing ☐ Email ☐ Other _____

- Reason individual or parent/legal guardian did not sign the form:
  - Refused
  - Did not respond after more than one attempt
  - Other _____

GOOD FAITH EFFORTS

The following good faith Efforts were made to obtain the individual or paret/legal guardian's signatures. Please document with date, times, individuals spoken to and outcome, as applicable, the efforts that were made to obtain the signatures. More than one attempt must be made.

- In person by conversation: _____
- Telephone Contact: _____
- Mailing: _____
- Email: _____
- Other: _____

Staff Name: _____ Position: _____ Date: _____

Staff Member Signature: _____Date: _____

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Thank you for choosing The Office of Dr. Maryam Nejat. It is exciting to have you join our patient family! We believe in the importance of quality dental care and will strive to provide the best dental treatment possible. Also, we understand the financial limitations that influence your choice of care and want to assure you of our flexible approach by offering several payment options.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND CARE CREDIT

Terms and Conditions Payment terms:

Maryam Nejat, D.M.D requires payment in full prior to beginning of your treatment. Once a customized treatment plan has been formulated for your dental needs, Dr. Nejat or a team member will discuss further payment options.

FOR OUR PATIENTS WITH DENTAL INSURANCE: We will be happy to work with you and your insurance carrier to maximize your benefits. Payment of insurance co-payment and co-insurance amounts are expected at the time of your visit. If you choose to assign your insurance benefit directly to us we will then bill your carrier for the balance of your payment. If payment is not received from your insurance carrier within 60 days, the balance owed becomes your responsibility. Some insurance companies send payments directly to patients instead of to the dental provider. It is your responsibility to endorse and submit these checks over to Maryam Nejat, D.M.D within ten days of receipt.
INITIAL_____

Cancellation Policy/Returned Check Fee: A fee of $45 is charged for patients who no show or cancel their appointment more than 1 time without 24 hour notice. A fee of $40 is charged for a returned check.
INITIAL_____

Small Balance Policy: As a courtesy, we would like to limit the amount of statements you receive. Therefore, it is our office policy to keep a credit card on file so we may take care of any balance under $50.00. You will be notified prior to the payment and receipt will be issued at your request.
INITIAL_____

Electronic

DEPOSIT POLICY: Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a deposit of half of the treatment fee to make your reservation.
INITIAL_____

I have read and agree to the Financial Policy and the Cancellation Policy of Maryam Nejat D.M.D. I agree to a credit card on file that may be charged for small balances and deposits for future appointments.

Credit Card Number_____ CDC code_____ Exp Date_____

Signature of Patient or Responsible Party: _____ Date: _____