



DR. YU & ASSOCIATES
PRACTICING THE FINE ART OF PERIODONTICS & IMPLANTOLOGY

DAVID H. YU, DDS, MS
NICOLE S. LITIZZETTE, DDS, MS

Patient's Full Name: _____

Date of Birth: _____

Acknowledgement of Privacy Practices

By my signature below, I acknowledge that I have read the Notice of Health Insurance Portability and Accountability Act (HIPAA) and Financial Policy of Dr. Yu and Associates that is available to review upon request. I understand that Dr. Yu and Associates reserves the right to change their notice and policies, & upon request will mail a copy of any revised notice to the address I have provided. Under the HIPAA, I understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I may revoke this consent in writing, except to the extent that Dr. Yu and Associates has already taken action in reliance thereon.

Signature of Patient, Parent or Guardian

Date

Consent for Services and Disclosure of Health Information

My signature at the bottom grants permission for Dr. Yu and Associates, to call, text or email me on my cell, at home, work, or leave a message to discuss matters related to my treatment. If needed, I give permission for any designated trained employee at Dr. Yu & Associates to take a CT scan (Computed Tomography scan). At your request we can have a Board Certified Maxillofacial Radiologist read your images. I give Dr. Yu and Associates permission to release my information to other medical/dental providers and insurance companies, when necessary, for treatment. In addition to dental/medical providers, I give permission for Dr. Yu and Associates to share my protected health information with the following individuals:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Financial & Cancellation Policy

Full payment of our fees is due at or before the time of treatment. In the event of default, collection & legal fees are the responsibility of the patient/guardian. Patients are typically on a waiting list to reserve time in our office. Without proper notice, patients on this wait list do not have the opportunity to fill an open appointment. In an effort to keep costs low, Dr. Yu and Associates reserves the right to charge a fee for any missed, cancelled, or re-scheduled appointments. The fees will be as follows: \$100 for surgery appointments with less than five (5) business days notice and \$25 for hygiene appointments with less than two (2) business days notice. Our e-mail reminder service is offered as a courtesy. You are responsible for confirming or notifying us of any issues regarding a scheduled appointment. If you have questions about our financial policy or cancellation policy, please request to speak with us personally.

Signature of Patient, Parent or Guardian

Date