John F. Como, D.D.S., P.C.
140 Lockwood Ave., Suite 209
New Rochelle, NY 10801
Phone (914) 632-1111/Fax (914) 235-5959

PATIENT HIPPA AWARENESS

Having read the John F. Como, D.D.S., P.C. Notice of Privacy Practices, I hereby consent to John F. Como, D.D.S., P.C. using and disclosing protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). John F. Como, D.D.S., P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Privacy Officer.

With my permission, the office of John F. Como, D.D.S., P.C. may call my home or other designated locations and leave a message on voicemail at home, work, or cellular in person, or via e-mail or text in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of John F. Como, D.D.S., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, e-mail reminders and patient statements every effort will be made to mark them Personal and/or Confidential.

I have the right to request that John F. Como, D.D.S., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this, I am allowing John F. Como, D.D.S., P.C. to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

FINANCIAL AGREEMENT

The fee for your treatment is determined by the complexity of the treatment required. The fee is payable in full at the time of service unless other arrangements are made in advance. We will be happy to assist you in completing your insurance forms in the event that you have insurance benefits available to reimburse you for fees paid to John F. Como D.D.S., P.C. Upon request we will furnish you with a walk-out statement which is especially prepared to assist you with your insurance claim. The patient is responsible for submitting their claim to their insurance carrier. The office of John F. Como D.D.S., P.C. does not submit insurance claims for patients, but may assist with claims submitted on a case by case basis. If any additional information is requested by your insurance company please contact our office. All fees are the direct obligation of the patient it is the patients responsibility to verify coverage and requirements with your individual carrier.
All remaining balances past due by 60 days, patient/guarantor will be responsible for 1 ½ % service charge per month. There may be a minimum $50 fee for all scheduled appointments broken without at least 48 hours prior notice. For your convenience we accept credit cards, cash and personal checks.

_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
Print Patient's Name	Print Name of Legal Guardian