ASTRA DENTAL
Notice of Privacy and Confidentiality Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. IT'S OUR LEGAL DUTY. We are required by applicable federal and provincial law to maintain the privacy of your health information. We are also 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. We are committed to collecting, using and disclosing your information responsibly.

In this office, Dr. Ana Santana Guerrero acts as the Privacy Information Officer / Custodian. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. We are all trained in the appropriate uses and protection of your information.

The purposes for which Personal Information is collected in this Office will be identified before or at the time it is collected. This Office collects Personal Information that is reasonably appropriate in the circumstance in order to fulfill the purposes disclosed by our Office, as well as otherwise permitted under applicable laws including for the following purposes:

- to deliver safe and efficient patient care;
- to identify and to ensure continuous high quality service;
- to assess your health needs;
- to advise you of treatment options;
- to enable us to contact you;
- to provide health care;
- to establish and maintain communication with you, including to distribute health care information and to book and confirm appointments;
- to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally;
- to communicate with other treating health-care providers, including specialists and general dentists, who are the referring dentists and/or peripheral dentists;
- for teaching and demonstrating purposes on an anonymous basis;
- to allow us to efficiently follow-up for treatment, care and billing;
- to complete and submit dental and health services claims for third party adjudication and payment;
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario (RCDSO) in a timely

fashion, when required, according to the provisions of the Regulated Health Professions Act (RHPA);

- to comply with agreements/undertakings entered into voluntarily by this Office or a Service Provider with the RCDSO for regulatory and monitoring purposes;
- to permit potential purchasers, practice brokers or advisors to evaluate this Office, including an audit, on a confidential basis;
- to deliver your charts and records to insurance carriers to enable them to assess liability and quantify damages, if any;
- to prepare materials for the Health Professions Appeal and Review Board as required;
- to manage patient and clients' accounts, including invoicing, processing credit card payments and collecting unpaid accounts;
- to communicate with insurance companies and to otherwise process requests by you;
- for internal management purposes, including planning, resource allocation, policy development, quality improvement, monitoring, audit, evaluation, reporting, obtaining or processing payment for health services and human resource management; and
- to comply generally with Privacy Laws and all other applicable regulatory requirements.

When you sign this Notice of Privacy and Confidentiality Practices, you will be deemed to understand and accept this Office's collection, use and disclosure of your Personal Information for the specified purposes, in each case subject to the Code and Privacy Laws. If new purposes arise for the use and/or disclosure of your personal information, we will seek your approval in advance. You may withdraw your consent upon reasonable notice to our Office.

I have reviewed the above information and I agree that Dr. Ana Santana Guerrero and Astra Dental can collect, use, and disclose personal information about me as set out above.

_____	_____
Signature (patient or parent)	Patient's Name
_____	_____
Date	Signature of Witness

ASTRA DENTAL
FINANCIAL AND TREATMENT CONSENT

Date: _____

Patient's Name: _____

The undersigned hereby authorizes Dr. Ana Santana Guerrero or the Associate Dentist to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I authorize the Doctor to perform any and all forms of treatment and further authorize and consent that Doctor chooses and employs such assistance as deemed fit.

I also understand the ultimate responsibility for the payment for the services rendered by Dr. Ana Santana Guerrero or the Associate Dentist is my own. I have been informed that the office will bill my insurance for the treatment directly if possible, but that the responsibility of payments of Dental Services provided in the office for me or for my dependents is mine, due, and payable at the time of services rendered unless financial arrangements have previously been made.

Signature: _____

ASTRA DENTAL
APPOINTMENTS AND CANCELLATION POLICY

Date: _____

Patient's Name: _____

Making an appointment means that we are reserving a room for your specific needs. We ask for at least 48-hours' notice if ever you change your appointment with us. By doing this, you give us the chance to give your reserved room to another patient who could use it.

We charge $50 for no-shows OR late cancellations for scheduled appointments. If you have repeatedly cancelled or missed appointments with us, you will also lose appointment privileges in the future.

We believe that time is precious for you, our patients. When booking an appointment with us, we reserve a room for you, check and prepare your records, and prepare special tools for your appointment. We try to be prompt except for emergencies. We ask you to give us the same courtesy.

I understand the Cancellation Policy and I will try my best to inform the office of any changes to my appointments 48 hours prior.

Signature: _____

ASTRA DENTAL
PATIENT RESPONSIBILITY (CO-PAYMENT)

What is co-payment?

Co-payment — also called co-insurance — is the portion of the bill that is your own responsibility. It's the most common way for dental plans to limit their costs, thereby providing various plans with an assortment of benefits and price points for the purchaser to choose.

Some plans are also taking other approaches to limit plan spending: setting annual deductibles, capping the dollar amount, or limiting the number of visits covered within a year.

How much do I have to pay?

That depends on your plan.

An 80-20 co-pay is common for basic procedures such as x-rays, cleaning, fillings, and root canals. This means the dental plan covers 80%. A 50-50 co-pay is common for major procedures such as crowns and bridges.

But there are many variations; be sure to check your specific plan. There might be annual deductibles, frequency limitations, and annual dollar maximum on your plan.

Can my dentist waive my co-payment?

No. The waiving of a co-payment is insurance fraud and is against the law. Your dentist could be heavily fined, or even lose their license. If you are found involved in fraud, your insurance might be terminated, and you could jeopardize your current job position.

When you and your dentist sign the claim form that goes to the insurance company, you are stating which services were provided and how much, in total, was charged. The insurance company pays its share based upon the assumption that you will do the same.

Your dental plan is a valuable benefit. Before you ask your dentist to waive a co-payment, think about the consequences to you and your dentist.

I understand that I must pay the co-payment and any deductible as per my insurance agreement at time of service:

_____ _____ _____

Signature (Patient or Parent) Patient's Name Date

ASTRA DENTAL
ELECTRONIC CLAIMS AUTHORIZATION

Each patient must sign authorizing the dental office to send his or her claims electronically:

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

This authorization shall continue in effect until the undersigned revokes the same.

Patient's Name: _____

_____ _____
Signature of subscriber, parent or guardian Date

Each patient for which we accept assignment of benefits must sign below:

I hereby assign my benefits, payable from claims submitted electronically, to Astra Dental associates and authorize payment directly to whom has provided the services.

This authorization shall continue in effect until the undersigned revokes the same.

Patient's Name: _____

_____ _____
Signature of subscriber, parent or guardian Date