Bernal DENTAL CARE
Yuhao Gao, DDS, Ph.D
3283 Bernal Ave, Ste 108, Pleasanton, CA 94566 (925)249-9242

Office Policies & Consents

____ HIPAA

Initial

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations by Yuhao Gao, D.D.S. I have the right to read the Notice of Privacy Practices before deciding to sign this consent. This notice provides a description of uses and disclosure taken to my protected health information and of other important matters about my protected health information.

I also have the right to revoke this consent at any time by giving Yuhao Gao D.D.S. written notice of revocation submitted to the office manager or treatment provider. (Notice: revocation of this consent will not affect any action taken in reliance on this consent before receiving the revocation, and that Yuhao Gao, D.D.S. may decline to give any treatment or to continue treatment once this Consent is revoked.)

____ ASSIGNMENT AND RELEASE

Initial

I certify that I, and/or my dependent(s), have insurance coverage indicated on the Patent Registration and assign directly to Dr. Yuhao Gao may also use my healthcare information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is competed for one year from the date of my last treatment.

____ DENTAL MATERIALS FACT SHEET

Initial

I acknowledge that I have read the Dental Material Fact Sheet (The Facts About Fillings) developed by the Dental Board of California. I understand that this sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations. I understand that I should review this information to make a fully informed decision regarding dental restoration treatment. I also understand that I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with the dentists.

____ I ACKNOWLEDGE, UNDERSTAND, AND ACCEPT THE FOLLOWING OFFICE POLICIES:

Initial

(24 Hour Cancellation Policy): Each patient is required to provide advanced notice to allow Yuhao Gao, D.D.S. to arrange office schedules. Failure to notify any cancellation of appointments 24 hours in advance will result in a $25 fee. Three such incidents shall be considered as automatic noncompliance and withdrawal of dental treatment.

(Payments) Co-payments and/or Payments are due when services are rendered. An estimate of your financial responsibilities shall be provided prior to or during your visit. If you did not receive an estimate a copy shall be made immediately upon request.

(Insurance Claims) We are NOT contracted with your insurance company(ies) and therefore have no authority of eligibility, benefits, fee schedules, or other membership entitlements. Thus as a courtesy, Dr. Yuhao Gao will process insurance claims on your behalf but balances after 60 days will be submitted to collections.

(Information Update) Each patient is responsible for updating any changes to health, medication, insurance coverage, and/or personal information including work performed at other offices, contact information, job changes, etc.

Patient/Guardian Signature_____ **Date**_____