



727 Simms Street Suite E
Golden, CO 80401
(303) 232-3636

Welcome to Golden View Dental. We would like to take a moment of your time to introduce you to our office and our office policies.

We have a great staff with Dr. Welch, our hygienists, Louise Martin, Theresa Woytek and certified expanded duty assistants to provide you with the best possible dental treatment. Our office can cover most of your dental needs from cleanings, restorative work, endodontics, periodontics, oral surgery, laser surgery, orthodontics using the new Fast Braces™ technology and introducing; Cerec 3D CAD CAM, for superior precision and time saving restorations. We also have 3D imaging available.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. Our office does not accept payment arrangements. We accept cash, personal checks, Visa, Master Card, Discover, American Express and Care Credit (please ask for more information).

WHILE OUR OFFICE IS HAPPY TO FILE YOUR DENTAL CLAIM, IT IS THE PATIENTS RESPONSIBILITY TO UNDERSTAND THE STRUCTURE OF THEIR DENTAL BENEFITS.

We strive to run our office on schedule, please take into consideration the exception of emergency situations. We will give the same care to you that we provide to others.

Your dental records must remain on file with Golden View Dental. However, if you wish to have copies of your records, please give the office one week's notice, and we will be glad to provide them to you.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO GIVE US A CALL.

I HAVE READ AND UNDERSTAND THE ABOVE.

Signature

Date



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PROTECTING YOUR PRIVACY

Protecting your privacy and your medical information at our office, over the phone, fax or the Internet is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. It is one of our highest priorities. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization and otherwise meet your needs. We also may access information about you when considering a request from you or when exercising our rights under the law or any agreement with you. We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures. We limit who receives information and what type of information is shared.

1. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
2. To help us offer you our services, we may share information with companies that work with us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
3. Patient-specific personally identifiable data is released only when required to provide a service to you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless your give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies. The practice does not share any customer information with third-party marketers who offer their products and services to our patients.



HIPA PRIVACY NOTICE

PLEASE READ CAREFULLY

You understand that, as part of the provision of healthcare services, the doctor creates and maintains health records and other information describing, among other things, your health history, symptoms, examinations and test results, diagnoses, treatment and plans for any future care or treatment. You have been notified with a notice of privacy practices which provides a more complete description of the notice prior to signing this consent. You understand that you have the right to object to the use of your health information for directory purposes.

You understand that you have the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities), under writing, premium rating, conducting or arranging medical review, legal services, and auditing functions, etc, and that the doctor is not required to agree to the restrictions requested. By signing this form you consent to the use and disclosure of health information about the patient for the purposes of treatment, payment, and to revoke health care operations.

This consent is given freely with the understanding that: a) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without your prior written authorization except otherwise provided by law, b) A photocopy or fax of this consent is as valid as the original, c) You have the right to request that the use of your Protected Health Information, which is used for the purposes of treatment, payment or healthcare operations be restricted. You understand that the doctor and you must agree to any restriction in writing that you request on the use and disclosure of your Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of your Protected Health Information, which have been previously agreed upon.

Signature

Date

