



NEW PATIENT REGISTRATION FORM

Name: _____ Today's Date: _____ Date of Birth: _____

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouses Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Work Phone: _____ Cell: _____ Email: _____

Occupation: _____ Employer Name & Address: _____

Dental Insurance: Yes ☐ No ☐ Name of Insurance: _____

Policy Holder: _____ Policy Holder SS#: _____ Policy Holder's Birthdate: _____

Policy Holder I.D. number _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ Phone #: _____

Person Financially Responsible: _____ Phone: _____

How did you find out about us: (If you were referred by someone please let us know who to thank): _____

Please share with us how you would prefer we contact you. Check one preference or provide an order of preference so we can stay in touch: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail ☐ Text Message

DENTAL HISTORY

1. Please describe the primary reason (s) for your visit (concerns):

2. How long has this been going on and what would you like done?

3. Have you ever had a bad experience at a dental visit?
If you answered yes please let us know what we can
do to make your visit more comfortable.

☐ No ☐ Yes

Have you ever suffered from, or been told that you may have any of the following?

☐ Gum Disease

☐ Bite issues

☐ Jaw pain or TMJ

☐ Bad Breath

☐ Headaches or Migraines

☐ Bruxism or Grinding

☐ Sleep Apnea

☐ Snoring

☐ Dental Pain

SMILE EVALUATION

1. Do you like the appearance of teeth, your smile
If not, explain

☐ Yes

☐ No

2. Are your teeth all in alignment (straight)?
If not, explain

☐ Yes

☐ No

3. Do you have spaces that you do not like?
If not, explain

☐ Yes

☐ No

4. Do you like the color of your teeth?
If not, explain

☐ Yes

☐ No

5. Do you like the shape of your teeth?
If not, explain

☐ Yes

☐ No

6. Are your teeth.....?

Chipped_____ Protruding_____

Hidden_____

7. Do you like the way that your teeth come together?

☐ Yes

☐ No

8. Are there old fillings or dental work that you don't like looking at?
If not, explain

☐ Yes

☐ No

9. What would you like to change the most in the appearance of your teeth? If not, explain

10. How would you like your teeth to look?

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

SITUATION

Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting Quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient (or Legal Guardian Signature)

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

**PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 9/22/13, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or



disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also



request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Dr. Lewis Yu, D.M.D.

Address: 4543 Stoney Batter Road, Wilmington, DE 19808

Telephone: 302.239.1641

Email: info@allaboutsmlsde.com



NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY EFFECTIVE: SEPTEMBER 22, 2013

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.

Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Dr. Lewis Yu, D.M.D.
Address: 4543 Stoney Batter Road, Wilmington, DE 19808
Telephone: 302.239.1641
Email: info@allaboutsmlsde.com



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of *All About Smiles, P.A.*, Notice of Privacy Practices, which has an effective date of 09/22/13, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient (If not signed by the Patient)

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics

Other?

☐

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____



FINANCIAL POLICY

We are committed to providing you with the highest quality of care. Having a clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete our patient information and medical history forms, read and approve our privacy policy (HIPAA) and submit your insurance card for photocopying.

We are considered a “*fee for service practice*”. What this means is that payment is expected at the time of service. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care that you need. We accept cash, check, VISA, MasterCard, Discover and American Express. We offer a 5% discount for check/cash patients. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options (CareCredit). Check policy: If your check is returned for any reason, a \$45.00 processing fee will be charged in addition to the amount of the check. Interest at a rate of 1.5% per month will be added to your account per month on accounts of 90 days. If an account is referred to, or purchased by a collection agency, a fee will be assessed 50% of the outstanding balance and added to your ledger. In addition you will be responsible for any fees added by or incurred by the collection agency collecting the debt.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

If at any time you have any questions regarding our fees, financial policy or your responsibility please do not hesitate to ask any member of our business team.

INSURANCE IS A CONTRACT BETWEEN YOU AND THE INSURANCE COMPANY.

Whether you have purchased dental insurance on your own or your employer has provided it for you, you are fortunate to have it and we will go the extra mile to help you to maximize the benefits provided by your specific plan. As a courtesy, we will do the verification of benefits, file all claims and do any necessary follow-up. Most insurance companies usually pay a percentage of the fee, and this varies from plan to plan. Although your insurance plan may say that services are paid at 100%, 80%, 50%, etc., the plan may contain clauses and limitations on yearly maximums, frequency limitations and set fee allowances and are not always clearly specified. We will do our best to *estimate* what your insurance will pay, what your out-of-pocket will be and then help you to understand how your individual plan works.

We will electronically submit the claim on the day of your appointment and you can usually expect payment from your insurance company within 7 to 10 business days. **You, the patient, are ultimately and completely responsible for the payment of your account.**

If you have any questions or concerns about your finances or treatment please let us know and we will work out a personalized treatment and finance option that will suit your budget and lifestyle.

I have read the above and I understand that I am completely responsible for payment on my account and agree to the above terms.

Name

Date