

Patient Registration Information

Please fill out all available information on this page and bring it to your appointment or send it to us in advance. Without complete information we are unable to process insurance claims.

Patient Information		
Last Name	First Name	Middle Name
Prefers to be called:		
Street Address		
City	State	Zip
Home Phone	Work Phone	Mobile Phone
e-mail address		
Sex	Marital Status	SS Number
Birthday		

Account Information		Same as Patient Info?	
Last Name	First Name	Middle Name	
Street Address			
City	State	Zip	
Home Phone	Work Phone	Mobile Phone	
e-mail address			
Sex	SS Number	Birthday	
Relationship to the patient:			

Getting to know you	
<i>Is a member of your family or a relative a patient at our office?</i>	
Name	Relationship
Who referred you to our office?	
In an emergency, who should we call?	
Relationship	Home Phone
	Work Phone

Insurance Information	
Primary Dental Insurance	
<i>Note: This is your own plan if you are insured through your work, or your spouse or oldest parent if you don't have insurance on your own.</i>	
Name of the Insured Party	Relationship to Patient
Insured's Employer	
Insured's Birthday	Insured's SSN
Insurance Plan Name	Group Number
Insurance Company Name	
Insurance company mailing address name	
Insurance company Street or P.O. Box	
City	State
Insurance Company Phone Number	

Secondary Dental Insurance	
<i>Note: This will be your spouse's plan if you are covered on each other's plan, or your youngest parent if you are covered on both parents' plans.</i>	
Name of the Insured Party	Relationship to Patient
Insured's Employer	
Insured's Birthday	Insured's SSN
Insurance Plan Name	Group Number
Insurance Company Name	
Insurance company mailing address	
Insurance company mailing address name	
Insurance company Street or P.O. Box	
City	State
Insurance Company Phone Number	

Health History Form



American Dental Association
www.ada.org

E-mail:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:	Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>
Last First Middle Address:	City:	State: Zip:
Mailing address Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone:
		() () <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems:	(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Active Tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: Phone: <i>Include area code</i>				If yes, what was the illness or problem?			
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes	No	DK				Yes	No	DK
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes	No	DK				Yes	No	DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No	DK	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Patient Acknowledgements and Consents

<p>_____</p> <p>Initial</p>	<p>Insurance Policy All fees incurred at this office are the responsibility of the patient. As a courtesy, however, we do file most dental insurance. Whenever possible, we will estimate the benefits from your insurance plan and require that you pay only deductibles and co-payments initially. Many insurance companies have specific exclusions, waiting periods, limits, etc. that we are unaware of, and our estimates are not guarantees of payment. Any balance resulting from a lower reimbursement from your insurance company than initially estimated is due in full. In addition, if the insurance company fails to make payment within 60 days, the entire balance becomes due from the patient. For more information read the Insurance Facts section of the new patient packet (Appendix 1).</p> <p>By signing below, I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me. In addition, I authorize the release of any information necessary to obtain payment from the insurance company. (We will use this as your signature on file to be used on all insurance claims.)</p>
<p>_____</p> <p>Initial</p>	<p>Financial Arrangements All fees are due in full at the time of service unless an alternate written financial arrangement has been agreed upon. If the cost of treatment is higher than patients can afford at one time, we do offer payment options. For more information read the Financial Arrangements section of the new patient packet (Appendix 2) or ask our staff, who will be happy to discuss options with you. All financial arrangements should be discussed and finalized prior to scheduling treatment.</p> <p>By signing below, I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. In the event payments are not received by agreed upon dates, I understand a finance charge will be assessed on my account. I also agree to pay any collection costs necessary, including a reasonable attorney's fee, should my account become overdue.</p>
<p>_____</p> <p>Initial</p>	<p>Appointment Policy In order to give the best quality care, we reserve individual appointment time for each patient, trying to always start and end appointments on schedule. Because of this, we ask that you give at least 48 hour notice when you need to change your appointment. Non-refundable prepayment may be required for lengthy or higher-cost appointments. There will be a fee charged to you for any changed or forgotten appointments that occur in less than 48 hours of the appointment time.</p>
<p>_____</p> <p>Initial</p>	<p>Royalty and Publishing Rights Release for Models, Photos, etc I authorize the doctor or his designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs and to document my treatment. The doctor may use such items for obtaining insurance benefits, teaching, publishing in professional literature, technique demonstration, marketing, and patient education without compensation or royalties.</p>
<p>_____</p> <p>Initial</p>	<p>Consent to receive treatment Upon diagnosis I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for complete recital of any possible complications.</p>
<p>_____</p> <p>Initial</p>	<p>Notice of Privacy Policy We care about your privacy and the privacy of your personal health information. By law we are required to maintain your privacy, and to give you notice of our privacy policies and practices. Our Privacy Policy is included as a part of this document (Appendix 3). We also have a copy posted at the office. If you like, we can print an extra copy of the Privacy Policy at our office for you to take with you. You can also view or download the form on our web site.</p>

Signature

I agree to abide by this office's Insurance, Financial, and Appointment Policy.
I agree to the x-ray, model, photographic release.
I want my dental needs to be treated at this office.
I have been offered the opportunity to read the office's Privacy Practices, or chosen that I do not want to read it at this time.

Signed: _____ Date _____

(If signing for a minor only) Relationship to the patient: _____

Appendix 1: Insurance Facts

Insurance—What a mess!

Dental practices are faced with big challenges when it comes to working with insurance companies. With so many companies and so many different policies being issued, there is no way we can keep up with what each one pays. Therefore we have established a strict policy regarding dental insurance. Please be aware of this: Your insurance policy is an agreement between you and an insurance company. They agree to pay certain amounts for your dental care—amounts which are determined by the contract purchased by your employer. The insurance company has no contractual obligation to your dental office. On the other hand, your dental bill is the result of an agreement between you and your dentist. Your dentist does work for you in exchange for a fee. You are responsible for full payment of your bill regardless of the status of your insurance claim. The purpose of this document is to inform you of some of the common problems we encounter in dealing with dental insurance plans.

Waiting Periods

There is often a misconception that once you have dental insurance you are covered for any and all expenses you incur at a dental office. But in many instances only certain things are covered, and the coverage that you do get goes into effect incrementally. An example might be a plan that covers preventive and diagnostic services immediately, restorative services after six months, then makes you wait a full year before covering crowns, bridges, or dentures. Of course, those waiting periods have nothing to do with when you need care, only when they will pay for it. You should make yourself aware of any waiting periods that apply so you don't get any financial surprises.

Annual Maximums

Dental Insurance plans have annual maximum payouts that are allowed. This is exactly the opposite of major medical insurance plans that pay *all* charges over a set amount known as your stop loss. Unfortunately, the amount that they pay out per year has not increased much over the past 20 years, while the costs of dental services have gone up substantially. If you need anything more than the normal preventive care, a filling or two, and a single crown, you'll probably exceed your annual maximum.

Just because you have exceeded the annual maximum for your plan does not mean that you should put off recommended dental care. Delays can jeopardize your health, which is a bad choice. Some patients have mistakenly assumed that annual maximums are intended to gauge how much dentistry a person should have in a year. The fact is they are intended to assure the profitability of the insurance company—nothing more. If you find yourself in need of extensive dental work within a year, you will likely have to fund the care on your own.

Fee Schedules

Some dental insurance plans pay on a fixed fee schedule rather than a percentage of the cost incurred. That fee may be the entire amount charged or very little of the amount charged. Our fee is not affected by whether they pay much or little. Be aware that fee schedule plans often have low benefits to the patient, and leave you paying more out of your own pocket.

Usual, Customary, and Reasonable (UCR) Limitations

Sometimes insurance companies limit amounts they pay for dental procedures and claim that the charges exceed the usual, customary and reasonable charges for your area. But how are those amounts determined? There is no policing agency to make sure that UCR limitations are fairly calculated. There is no mandated reporting of the fees charged by area dentists, so the only way a company knows fees is by collecting data from the claims they receive. It is not scientific; it's always based on old data, and is always based on averages.

Although we strive to keep fees affordable, there may be times that your insurance company says a fee we charge is above average. They could be right, because we don't do average work here. We continually strive for excellence. It is impossible to consistently do above average work and charge average fees. But we always give excellent value by keeping fees reasonable, and using the best materials and techniques available. We stand behind our work, and use the highest possible standards when placing restorations for our patients.

Things to consider:

- When the insurance company gets the numbers from all the claims submitted, there will be a range of fees—some high, some low. They know that any given claim falls in a percentile range. What percentile do they accept to pay, and what percentile is too high? As you can imagine, a plan that pays all claims at or below the 90th percentile is a lot better than a plan that pays all claims at or below the 50th percentile.
- You will probably not be told the percentile that your plan considers acceptable.
- You will not likely be told what charges make up the fees that the insurance company uses to determine UCR. They may be from your zip code, your city, or your state. If you live in an area where costs are high, but the insurance company includes fees from areas where costs are low, your reimbursement will be decreased.

Treatment Exclusions

Some insurance plans exclude specific procedures. These exclusions may have nothing to do with whether or not the procedure is needed or appropriate. In many instances the excluded procedures are simply a matter of keeping the cost of the policy low for the employer. Insurance companies have to make the price of their policies competitive in order to sell them. Then they have to keep their payout low enough to make a profit. Cosmetic and experimental procedures are almost always excluded, as are dental implants. Other commonly excluded services include Nitrous Oxide Sedation, Inlays and Onlays, use of our Laser, Fluoride treatments, and tooth colored fillings. Sometimes what gets excluded is the best treatment for your specific condition. That puts you, the patient, in the difficult position of choosing between the best care with no coverage and the inferior care allowed by your insurance plan with coverage.

Least Expensive Alternative

There are often a variety of ways to treat dental conditions. As you might imagine, some are far superior to others. If your insurance plan only pays for the cheapest possible treatment, you may be faced with having to pay for the better care without the benefit of insurance. There are many times that we have decided not to perform procedures we consider inferior or substandard. Although we are capable of performing the procedure, we know they are not in the patient's best interest. In that case you might have to find alternate means of financing your dental care.

Pre-Existing Conditions

There are times when insurance plans will not pay to fix any problem that existed before you were covered on that plan. It may be the replacement of a tooth that was lost prior to coverage, or treatment of a condition that was chronically building over time such as wear on your teeth. Unfortunately those long standing problems are often the ones most needing treatment. We will recommend going ahead with treatment even though insurance will not pay for the treatment.

Delay Tactics

Many times we find that insurance companies return claims—even ones that are filled out correctly with all needed information—and ask for some minor amount of extra information. In our opinion this is nothing more than an excuse to delay payment of the claim. Our office only files insurance claims as a courtesy to our patients—we have no obligation to do so. We allow our patients to pay the amount we guess that the policy will not cover. It is the responsibility of the patient to pay their entire dental bill if the insurance company fails to make payment for over 45 days, no matter what the reason. Our office is committed to providing you and the insurance company with all reasonable information in order to help them process your claim and get you the insurance benefits you deserve, but we cannot accept responsibility for the fact that some insurance companies pay slowly.

A Special Note About HMO's and PPO's

To keep our costs of dental services fair to all of our patients, we have made the decision not to enroll as providers in any dental insurance plan that requires discounting of fees or preferential treatment of any group of patients. We are not signed up as Preferred Providers because we feel that it shifts the burden of higher dental fees to those who have to pay all of their dental costs out of pocket. That is an unfair treatment in our opinion.

We realize that you have a choice to make about where you get your dental care, and we work hard to assure it will be worthwhile for you to go "out of network" if you have one of these more restrictive policies. For years we have maintained this policy, and although some patients have opted to go to a participating dentist, we have been gratified by the fact that many (if not most) have returned to our office because they thought the service was superior here than at other offices.

We file normal dental insurance claims daily, and allow our patients to pay only the estimated patient portion at the time of service. This amount is only an educated guess, and should not ever be construed as the final amount due. If there is a difference in the amount we think the insurance company will pay and what they actually pay we send a refund or a bill for the appropriate amount. Our computer tracks reimbursement amounts for each insurance plan, so it is usually pretty accurate.

Patients who have dental insurance plans that will not pay "out of network" providers are expected to pay for their dental care at the time of service unless prior financial arrangements are made. And although we do not accept assignment of benefits for HMO or PPO type plans, we will be glad to print out an insurance form or submit your claims electronically to make sure you get any allowable reimbursement for your dental expenses. **Realize that reimbursements are typically lower at an out of network provider than they would be if you went to an in-network provider.**

The Purpose of Dental Insurance—A Review

Dental insurance is a contract between an employer and an insurance company. It obligates the insurance company to pay you back for a percentage of the costs of any covered dental service. The terms of those contracts are widely varied, and are often dependant upon the cost of the plan. In many instances the plans pay a higher percentage on preventive care, a lower percentage on restorative care, and the lowest percentage on the things that cost the most. Therefore, dental insurance is a way to help you pay a portion of your dental costs, and it is not intended to be a pay-all. Regardless of what the insurance company pays, the patient is responsible for paying their entire dental bill.

What If I'm Dissatisfied With My Dental Coverage?

If you don't like the coverage you have, ask your employer to consider changing carriers or getting a better policy from the same carrier. If enough people express the interest in a better dental insurance plan, maybe you'll get what you request.

There is a chance that your employer is paying all they can afford for the coverage you are receiving. If that is the case, we can be grateful for the help we get, and look for other alternatives to cover expenses that are not covered by insurance. Ask us what expenses you can expect, and we can help you develop a dental savings plan.

Medical Insurance Claims

Some dental care is reimbursable by medical insurance. Examples include dental services rendered because of an automobile or other accident, or because of damage to teeth as a result of a medical condition. Although these are legitimate reasons to file dental claims under medical insurance, we have had very poor success at getting reimbursed for those services in a timely manner. Therefore we cannot accept assignment of benefit for services covered under medical insurance. We will not file medical claims for you, but we will be glad to assist you in filing your own medical claim. We will provide you with a list of all procedures for which we have charged you, the associated description of the service, and the clinical reason for the procedure. With this information and a completed form you should be able to file your claim.

Appendix 2: Financial Arrangements

When we diagnose a condition that requires treatment, we will always try to honor you by informing you of the services needed and the costs associated with the treatment. It is our objective to arrive at a method of payment that will allow you to comfortably receive and gratefully pay for our best quality care. Our payment options for uninsured care are listed below.

Whenever possible, we prefer to have payment for your entire treatment plan made before we begin treatment. It allows us to concentrate on giving the best care, and takes the focus off of collecting payment at each appointment. If you can pay the entire amount before beginning, it is our first choice. If that is not possible, please let the financial coordinator know how much you will be unable to pay up front, and select one of the listed options.

<p>Automatic Credit Card Charge By leaving your credit card on file with the office, we will charge the amount due for the services rendered each day. You will not be required to stop and pay after treatment.</p>	
<p>In House Financing For select patients, with a credit card on file as security we will allow you to pay out your treatment over a period not to exceed six months. This is ideal for those who need to spread the cost of treatment over a few months and want to avoid placing the charges on a credit card.</p>	
<p>Care Credit A financing company offering credit for medical and dental services. Care Credit allows small monthly payments over a longer time, but charges a higher interest rate. They are ideal for those who want to have the lowest possible monthly payments.</p>	<p>(800)859-9975 carecredit.com</p>
<p>Treatment Plan Pre-Payment For those with poor credit and no other financing options, we will set up a pre-payment plan to allow you to build up a credit balance until you have enough on account to receive treatment. This is ideal for those who need a scheduled plan to save for needed care.</p>	
<p>Assistance with personal and Home Equity loans We are able to give information to your bank to assist you in obtaining either a personal or a home equity loan. This is often advantageous for keeping interest rates low or giving the financing a tax advantage.</p>	

It is our hope that finances will never be a limiting factor in your receiving the best possible dental care. Please keep us informed if we can do anything to help you afford the fees incurred at this office

Appendix 3: Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state 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. This Notice became effective (12/08/2002), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information 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 or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact*

information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

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

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. You can pick up a copy at the office or request a copy to be sent by mail.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. 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.

Steven M. Richardson, D.D.S.
John B. Christensen, D.D.S.
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e-mail: admin@BreaDentistry.com