Darnestown Smiles
14128 Darnestown Rd, Darnestown, MD 20874
(240) 477 8251
darnestownsmiles.com

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature: Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for putting your trust in Darnestown Smiles LLC. Your oral health is our primary concern, and we are committed to providing our patients with the best care possible in a comfortable and caring environment.

1) NO SHOW, MISSED APPOINTMENT OFFICE POLICY When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you provide us with at least twenty- four business hours' notice. This courtesy allows us sufficient time to notify another patient needing our care that an appointment time has come available. If we are not available to speak with you directly, we do have a 24-hour voice message system/e-mail that you can leave a message regarding changing your appointment.

*There is a charge of $50.00 for not showing up for scheduled appointments and last-minute cancellations.

*If two or more appointments are missed or canceled without enough notice, we reserve the right to inactivate your family as patients in our office.
When your appointment is made, time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient or unexpected difficulties occur; you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. We understand things happen unexpectedly, but we ask for your assistance in this regard.

2) PATIENT TREATMENT CONSENT AND FINANCIAL AGREEMENT
I authorize Darnestown Smiles to perform such aids deemed appropriate to make a diagnosis of my dental needs. Upon such a diagnosis, I authorize the dentist to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist and mutually agreed upon me.
If your plan provides benefits for services in our office, you will be asked to leave the anticipated co-pay at each visit. THIS IS ONLY AN ESTIMATE. We will file insurance claims and submit the information necessary for your insurance company to process those claims. This is a service we provide as a courtesy to our patients, but please understand you have the contract with the insurance company and ultimately are responsible for payment. We will not guarantee payment will be made from your insurance company, nor will we be making a settlement on a disputed claim.

Our practice is committed to providing the best treatment possible to our patients. You are responsible for the cost of treatment provided regardless of an insurance companys arbitrary determination of the allowable fees.

Remember, you are the holder of the contract. It is your responsibility to ensure you understand the contract between you and your insurance company and to know the benefits available under your policy. If after 60 days your insurance company has not rendered payment the balance will become your responsibility.

I assign all dental insurance benefits to the extent permitted under my dental insurance policy to this practice. I agree and allow the provider to submit insurance forms and receive payment directly from the insurance carrier with the notation signature on file. I authorize my dentist to release treatment records/x-rays or any information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to pay for all services rendered on my behalf or my dependents at the time of service. I agree that my unpaid claims that the carrier does not pay or any balance that extends beyond 60 days from the date of service will be assessed a service charge of $20.00 late fee per month. In an event that this balance should be submitted to collections, there will be a fee of $100.00 charged to the account balance. If these fees should be added to your account, you will be notified by mail.

3) MINORS The adult accompanying a minor is responsible for full payment. For unaccompanied minors, nonemergency treatment will not be performed, unless prior payment has been made or charges have been authorized by the parent or legal guardian to a valid credit card accepted by our office.

4) SIGNATURE RELEASE I authorize the releases of dental/medical information necessary to either process my insurance claims for treatment performed by Darnestown Smiles, LLC, or when necessary, to other providers rendering medical/dental care. I assign all dental/medical/surgical benefits for treatment performed by Darnestown Smiles to which I am entitled to be paid to Darnestown Smiles, LLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Darnestown Smiles offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Darnestown Smiles will use reasonable means to protect the security and confidentiality of email information sent and received. However, Darnestown Smiles cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Darnestown Smiles and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Darnestown Smiles.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Darnestown Smiles, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Darnestown Smiles will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Darnestown Smiles cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Darnestown Smiles and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Darnestown Smiles.

Patient's signature: Date: