

Patient Agreement Policy

Payment Policy:

For all patients, payment-in-full is due on each day services are rendered.

Accepted forms of payment: Cash, Check, Debit, Credit: Visa, MasterCard, Discover, American Express and CareCredit.

To cover the cost of credit/debit card acceptance, a 3.5% processing fee will be automatically charged to card payments. No fee when using cash or check.

For our patients WITH dental insurance:

Parkview Dental Care is a Fee for Service, Out-of-Network Provider.

Out-of-Network Provider means: Dr. Bertagna is not in any dental insurance networks. HMO dental insurance does not have reimbursement benefits at this office.

If you have a PPO dental insurance, PPO insurance has out-of-network reimbursement benefits. Dental benefit limitations and exclusions are not the responsibility of Parkview Dental Care. All fees are the responsibility of the patient or guarantor regardless of what your dental benefits may or may not cover.

Fee for Service means: Payment in full is due on each day services are rendered. You will be happy to receive your dental insurance benefit check in the mail to you, usually in 2-4 weeks!

How this works: On each dental visit, the office will provide you your claim in a postage paid envelope to your insurance carrier for you to drop in the mail for your dental insurance benefits check. We prefer you to take your dental claim to the mailbox so that you know you dropped it in the mail for your reimbursement check.

For our patients WITHOUT dental insurance:

Payment in full is due at the time of each visit. Teeth treatment with Dr. Bertagna will receive a payment-in-full savings courtesy of 5% OFF. If you are 65 years old and older and receive teeth treatment with Dr. Bertagna, you will receive a senior savings courtesy of 10% OFF. There are no combined savings. There is no savings on teeth cleaning visits.

Fees:

- To cover the cost of credit/debit card acceptance, a 3.5% processing fee will be automatically charged to card payments. No fee when using cash or check.
- A fee is incurred on the account if the office does not receive 48 hours advance notice on not showing to your reserved appointment time, or rescheduling last minute.

I understand and agree to the terms and conditions of this Patient Agreement Policy.

REGISTRATION

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | | | | |
|--|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No
 Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

Allergies

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



HIPPA Privacy Practice

These privacy rules are assured under HIPAA (Health Insurance Portability & Accountability Act of 1996) and are enforced by the US Department of Health & Human Services Office of Civil Rights.

Your Privacy is Important to Us

We value our relationship with you. We respect your right to privacy, and we do everything we can to protect the information provided to us on behalf of our patients. We ask all our team members to follow our policies and procedures about patient privacy and information sharing.

We Protect Our Patient's Privacy:

- We restrict access to electronic patient information by using protected passwords when using company information systems.
- We do not leave customer information open or in view at workstations when our team members are not there. We lock up all our patient files before leaving the workplace.
- We share patient information only with team members as needed to complete service to the patient.

Your Personal Health Information Rights Are Protected:

The Health Insurance Portability and Accountability Act of 1996 helps to protect your rights to health coverage during events such as changing or losing jobs, pregnancy, moving, or divorce, and provides rights and protections for employers when getting and renewing health coverage for their employees. It also covers your rights with respect to protected health information.

"Protected Health Information" includes any individually identifiable information that is transmitted or maintained in any form or medium that relates to the past, present or future physical or mental health condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearing house.

- You have the right to access, inspect and obtain a copy of your protected health information.
- You have the right to amend your protected health information
- You have the right to request restrictions on uses and disclosures of your protected health information.
- You have a right to an explanation of the legal duties and privacy practices of those who have your protected health information.
- You have the right to receive confidential communications regarding your protected health information.
- If you feel your rights have been violated, you have a right to file a formal, written complaint with those who have your protected health information or with the Department of Health & Human Services
US Dept of Health & Human Services Office of Civil Rights, 200 Independence Ave, S.W., Washington, D.C.
20201 877-696-6775.

I have read Parkview Dental Care's Notice of Privacy Practices.

Print Patient Name

Signature of Patient or Responsible Guardian

Date