



# SANFORD SMILES

## FAMILY DENTISTRY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Middle Name \_\_\_\_\_ Nickname \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

Mailing address if different from above \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

Employer Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

### PRIMARY INSURANCE COVERAGE

Subscriber Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_

GROUP # \_\_\_\_\_

### SECONDARY INSURANCE COVERAGE

Subscriber Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_

GROUP # \_\_\_\_\_

### Responsible party for patient

Name \_\_\_\_\_



## **FINANCIAL POLICY**

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, DEBITS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS. WE ALSO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.**

### **REGARDING INSURANCE**

We request that any co-payments, deductibles, and any services known not covered by your insurance plan be paid at the time the service is provided. Any amount not paid by your insurance company is your responsibility. We cannot bill your insurance unless you bring in all insurance information at your initial visit. As a reminder your insurance policy is a contract between you and your insurance company. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy. These assessments are made by insurance companies based largely on financial models and not based on actual clinical judgement.

### **PATIENTS**

Adult patients are responsible for full payments at the time of service. The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service has been verified.

### **RETURN CHECKS**

There is a \$35.00 charge for all return checks to our office. Your bank may also charge you additional fees not associated with our office.



### **COLLECTIONS**

Any account that has not received payment in 60 days will be handled over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

### **REFUNDS**

Refunds for and final overpayment will be sent after all treatment is completed and insurance payments have been applied

### **MISSED APPOINTMENTS**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit which is \$75.00. Please understand that missed appointments times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your appointments.

***I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy***

**Patient Name** \_\_\_\_\_

**Patient /Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



## **APPOINTMENT POLICY**

Thank you for choosing Pittsboro Smiles Family Dentistry for your health care needs. To keep our patients informed and provide a healing environment for everyone, we have added a list of our new policies to make your visit and continuation of care more efficient. You can expect to be treated with courtesy and respect from our providers, management, clinical staff and administrative staff.

### **BEHAVIORAL EXPECTATION**

Patients (including visitors with patients) are expected to treat providers, management, clinical staff, and administrative staff with respect. Abusive/argumentative language is non-productive and will not be tolerated. It is our office policy to discharge patients from this clinic who disrespect providers, management or staff, in person or by phone.

### **LATE, CANCELLATION AND NO SHOWS**

Appointments must be cancelled at least 24 hours prior to the scheduled appointment time. We kindly ask for at least 24 hours' notice for cancellations. Appointments canceled within 24 hours or missed without notice may be subject to a \$75 fee.

To help us provide the best care for all of our patients, we kindly ask that appointments be confirmed.

To respect everyone's time, appointments may need to be rescheduled if you arrive more than 10 minutes late.

### **AFTER HOUR EMERGENCY**

In an effort to provide excellent care to our patients, our provider will make every effort to return calls within 24 hours. It is important that only emergency calls are placed after 5pm. If it not an emergency, you can call during our regular business hours or leave a message.

We understand that dental emergencies can occur unexpectedly. When emergency care is needed outside of our regular office hours, we are committed to doing our best to assist you. Please note that after-hours or weekend emergency visits are subject to an additional fee of \$250. This fee reflects the extra arrangements required to provide care outside normal hours, including coordinating the availability of the provider as well as our clinical and administrative team.



## HIPAA Notice of Privacy Practices

### **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may not be able to grant your request, but we'll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information

#### **Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.



### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information at the top of the page
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

#### **In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety

#### **In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

### **Our Uses and Disclosures**

How do we typically use or share your health information? We typically use or share your health information in the following ways.

#### **Treat you**

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition

#### **Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

#### **Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.



### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

- We can use or share your information for health research.

### **Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services



### **Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.



## RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, have received a copy of this practice's **FINANCIAL AND APPOINTMENT POLICY AND HIPAA NOTICE OF PRIVACY PRACTICES** and hereby give my consent to your use and disclosure of my protected health care operations.

**Patient's Name**

**Patient/Parent signature**

**Date**