Crescent Dental Associates - Financial & Responsibility Policy

Please read the following information thoroughly. This serves as your financial obligation and commitment to your appointments as a patient with Crescent Dental Associates.

Dental Insurance: Insurance plans are selected by you and your benefits are determined by your employer and your insurance carrier, not your dentist. You are responsible to know the scope of your insurance coverage and its limitations. Dental insurance is not a guarantee of payment and insurance companies typically will not pay in full for all of your treatments. If you receive a statement from our office and disagree with how your insurance carrier processed the claim, please call your carrier. You are responsible for payment of any deductible and co-insurance (co-payment) amounts at the time of service according to the terms of your insurance policy. Your insurance coverage is a contract between you and your insurer. Your account with us and payment of all charges are your responsibility, not your insurance company's. A written pre-determination of benefits from your insurance company is required to accurately determine your out of pocket cost. You will be required to pay for services rendered, in full, if our office is unable to verify your insurance information prior to treatment.

Initials ____

Delinquency: We reserve the right to charge and collect a fee of $100.00 for broken appointments - appointments that are canceled or broken without proper 48 hours (two business days) advance notice. You must confirm your appointment when you receive the confirmation call or text message to keep your reserved appointment time otherwise it will be removed from our schedule. Appointment times are reserved exclusively for you. If you do not present to your confirmed appointment, this takes away another patient's opportunity to have that appointment time, is waste of valuable office time and a financial burden on the practice. If two or more appointments are missed per family and we were not properly notified, you may not be able to schedule further appointments in the future. You may be dismissed from our practice or need to call on the day you are available and if we can accommodate you into our schedule on that same day, then you will be seen. A returned check fee of $20.00 will be added to your account balance and is collectible. Any account balance overdue longer than 90 days is considered delinquent, immediately collectible, subject to 5% interest on a monthly basis and will be sent to collection agencies with notice given to you in advance. You are responsible for any interest, legal or collections related fees. Payment in full of any past due balance and related fees are expected before any further treatment is rendered. **Initials ____**

Full Payment & Deposit: Payment in full (co-pay + deductible + any credit on the account + estimated insurance portion) is due at the time of service. We will submit a dental insurance claim for you and a payment is expected to be received from your insurance company usually within 4 to 6 weeks. Any outstanding balance after final insurance payment is your responsibility. A deposit equal to half of your portion of payment is required to reserve your next appointment time. Exceptions are payment plans already in effect. **Initials ____**

Payment Plans: We offer extended term interest-free and deferred-interest payment options through Care Credit. This program is offered through an independent financial institution and is subject to credit review and decision by them.

As guarantor of my account, I understand that I am solely responsible for all of the fees for dental treatment. I further acknowledge that I have received a copy of this office's financial policy and agree to its contents. We reserve the right to amend or change this policy without notice.

Print your name:___________________________ Patient's name if not self:__________________________

Patient or guardian signature:____________________________________ Date:______________________

CRESCENT DENTAL
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 here at Crescent Dental.

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 takes effect on June 1, 2008, 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 the Practice Administrator of this office.

Disclosures of health information: We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: W e may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use or 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. However nothing in this section requires Crescent Dental to oversee, supervise or dictate the professional activities of duly licensed dental professionals.
Telephone conversations: may be monitored for quality assurance and employee training.
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 you with your healthcare or with payment for your healthcare, but only if you agree in advance 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 the 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 institutions or law enforcement officials 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 voice mail messages, e-mail, postcards or letters).

Patient Rights:
Access: You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your healthcare information. We may charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. You may also request access by sending us a letter to the address at the end of this Notice. 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. 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.
Restrictions: 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 explaining 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.

Questions & 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 Heath 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 Heath and Human Services.

Contact Officer: Meggan Stanley
Telephone: (302) 230-0000, (302) 836-6968 - Facsimile: (302) 295-3607
Wilmington Office Address: 129 S. West St., Wilmington, DE 19801 - Bear Office Address: 100 Becks Woods Dr., Suite 102, Bear, DE 19701
Website: www.crescentdentalde.com, E-mail: info@crescentdentalde.com

Crescent Dental Associates

PATIENT INFORMATION

Name:________________________________ Birth Date:_________________ Social Security #:______________________

Address:_______________________________________ City:_______________ State:______________ Zip:________________

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Minor Email: ________________________________

Home Phone #:(_____) ________________ Cell #: (_____) _______________ Other Phone #: (_____) _________________

Occupation: _________________ Employer:_____________________________ Work Phone #: (_____) _________________

Work Address: ____

Are you a college student? ☐Yes ☐No ☐Full time ☐Part time College Name: ________________________

Spouse Name: ________________________ Employer: ___________________ Phone #: (______) _____________________

Person to contact in case of emergency: ______________________________ Emergency #: (______) _________________

Whom may we thank for referring you? ________________________________

INSURANCE INFORMATION

Name of insured: ____ Relation to patient:____________________________

Birthday:________________ Social Security or ID #: ____________________

Employer: ____

Insurance Company: _____________________________________ Group #: ____________________

SECONDARY INSURANCE INFORMATION

Name of insured: ____ Relation to patient:_____________________________

Employer: _________________________ Birthday: __________________ Social Security or ID #: ________________

Insurance Company:____________________ Group #: ____________________

RESPONSIBLE PARTY

(Person responsible for the account and finances)

Responsible person for this account: __________________________ Relation to patient: ___________________________

Address:_______________________________________ City:_______________ State:______________ Zip:________________

Date of birth: ________________ Phone #: (_____) ______________________ Email:_________________________________

REASON OF YOUR VISIT

Please indicate nature of your visit: ____

____

Please indicate if you are interested in receiving more information and exploring options for any of the following:

- ☐ Dental Whitening: At Home or In Office
- ☐ Getting Straighter Teeth: Invisible (Clear) or Conventional Braces
- ☐ Cosmetic Dentistry: Porcelain Veneers
- ☐ Replacement of Missing Teeth: Implants or Bridges
- ☐ Full Mouth Reconstruction: Repair of the Severely Worn Down Dentition
- ☐ Getting New Dentures: Conventional or Flexible
- ☐ Treatment for Achy or Popping Jaw Joint or Night-time Grinding of Teeth
- ☐ Treatment for Snoring
- ☐ Other: ____

____

HEALTH QUESTIONS

Do you have or have you ever had any of these conditions?

☐Yes ☐No Heart Trouble Type: ________________
☐Yes ☐No Infective Endocarditis
☐Yes ☐No Prosthetic Heart Valves
☐Yes ☐No Congenital Heart Disease
☐Yes ☐No Congestive Heart Failure?
☐Yes ☐No Artificial Joints Date: ________________
☐Yes ☐No Previously Infected Artificial Joint?
☐Yes ☐No Cancer: previously present
☐Yes ☐No Inflammatory Arthritis
☐Yes ☐No Immunosuppression
☐Yes ☐No Diabetes ☐Type1 ☐Type2 ☐controlled? ☐uncontrolled?
☐Yes ☐No Malnourishment?
☐Yes ☐No Renal Failure ☐Dialysis
☐Yes ☐No Hemophilia
To the best of your knowledge, do you know if you need antibiotic premedication prior to dental visits?

☐Yes ☐No Asthma? Date last episode? _______________
☐Yes ☐No Epilepsy? Date last episode? _______________
☐Yes ☐No Hepatitis? ☐A ☐B ☐C ☐D ☐E
☐Yes ☐No HIV or AIDS?
☐Yes ☐No Tuberculosis?
☐Yes ☐No Systhemic Lupus Erythematous?
☐Yes ☐No Radiation Therapy? ☐Past ☐Current
☐Yes ☐No Chemotherapy? ☐Past ☐Current
☐Yes ☐No Taking Corticosteroids?
☐Yes ☐No High Blood Pressure?
☐Yes ☐No Stroke? ☐multiple? Date:_________________
☐Yes ☐No Mental Health Conditions? _____________
☐Yes ☐No Autism
☐Yes ☐No ADHD
☐Yes ☐No Uncontrolled Thyroid Disease?
☐Yes ☐No Females: Are you pregnant?
Due date: ______________

If answered Yes to any of the above questions, or there is more information about your health which should be known please explain: ____
____
____

☐Yes ☐No Are you taking any medication? Please list:____
____

☐Yes ☐No Are you allergic to: ☐Latex ☐Penicillin ☐Cephalosporins ☐Codeine ☐Aspirin
☐ Other: ____

☐Yes ☐No Are you currently under a physician's care? Physician Name, Address and Telephone (if known):? ___________________
____

ACKNOWLEDGEMENT

1. **Parents/Legal Guardians**: I hereby certify that I am the legal guardian for the child whose information is entered in this form. I hereby authorize Crescent Dental, with my consent, to perform any and all necessary treatment in connection with the dental care of the patient above. Initial: _____
2. **Insurance Bearers**: You don't have to sign an insurance form at each dental visit. Crescent Dental will maintain this "Signature on File" for you.
   AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Crescent Dental for services rendered. Initial: _____
   AUTHORIZATION TO RELEASE INFORMATION: I further authorize any provider, insurer or organization to release any information regarding the dental history, treatment or benefits payable to the plan administrator or its authorized agent for the purpose of determining benefits payable.
   Initial: _____
3. **Financial Responsibility**: I understand that as a courtesy to me Crescent Dental will assist me in filing my insurance claims. However, I am completely responsible for all fees in their entirety. I am fully aware that my insurer may not pay in full (or at all) for all services provided by Crescent Dental. An estimate of expenses not covered by my insurance is due at the time of service.
   I have received Crescent Dental Notice of Financial Policy. Initial: _____
4. **Acknowledgement:** To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect, inaccurate or insufficient information can jeopardize my (patient's) health and ability to receive care at Crescent Dental. It is my responsibility to inform Crescent Dental of any changes in my medical status or dental insurance coverage policy. Initial: _____
5. **Privacy Policy**: I have received Crescent Dental Notice of Privacy Practices. Initial: _____

Patient/Parent/Guardian Signature:________________________________ Date:______________________

Thank you for choosing Crescent Dental!