

# PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ State: \_\_\_\_\_

SS #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Spouse's name & phone #: \_\_\_\_\_ Emergency phone # (other than spouse): \_\_\_\_\_

Primary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS #: \_\_\_\_\_

Name of your medical doctor: \_\_\_\_\_ Date of last visit to medical doctor: \_\_\_\_\_

Name of previous dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_

Referred to us by: \_\_\_\_\_

## DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sours? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care? _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>

# MEDICAL HEALTH HISTORY:

**Do you have, or have you had, any of the following?**

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Premedications required by physician</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____		
If so, please describe: _____		

**During the past 12 months, have you taken any of the following?**

	Yes	No
<b>Antibiotics or sulfa drugs</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anticoagulants (e.g., Coumadin)</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>High blood pressure medicine</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tranquilizers</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Insulin, Orinase, or similar drug</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Aspirin</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Digitalis or drugs for heart trouble</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nitroglycerin</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cortisone (steroids)</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Natural remedies</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nonprescription drug/supplements</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> _____		

**Are you allergic, or have you reacted adversely, to any of the following?**

	Yes	No
<b>Local anesthetics ("Novocaine")</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Penicillin or other antibiotics</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sulfa drugs</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Barbiturates, sedatives, or sleeping pills</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Aspirin, Acetaminophen, or Ibuprofen</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Codeine, Demerol, or other narcotics</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reaction to metals</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Latex or rubber dam</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> _____		

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**Women**

	Yes	No
<b>Are you taking contraceptives or other hormones?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you pregnant?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, expected delivery date:</b> _____		
<b>Are you nursing?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you reached menopause?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, do you have any symptoms?</b> _____		
_____		

Notes: \_\_\_\_\_

\_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_

Dentist Initial: \_\_\_\_\_

# VAUGHN FAMILY DENTAL

## CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Vaughn Family Dental is to provide you with convenient, accessible, high quality dental care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive timely for all scheduled appointments or cancel the appointment **24 hours** in advance. This policy allows us to make better use of our available appointments for those patients in need of dental care.

### Cancellation of an Appointment

You may cancel your scheduled appointment by calling our office during regular business hours.

Appointments are in high demand and your early cancellation will give another patient the opportunity to be seen by a provider.

### Missed Appointment Policy

A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment **24 hours** in advance, we will record this in the medical record as a "missed appointment". Each time you miss your appointment, you will be notified by telephone and you will be asked to re-schedule.

### Fees for Appointments – Financial Agreement

Effective July 1, 2016, Vaughn Family Dental will begin to charge patients when they do not present for scheduled appointments, after the second consecutive missed appointment.

Failure to cancel or re-schedule the appointment within 24 hours of the scheduled appointment time will result in a fee for a missed appointment. This fee will not be submitted to the health plan; it will be charged to the patient.

We understand that flexibility is important and patients may be allowed one "free" missed appointment charge.

The missed appointment fee structure is **\$35** for all types of appointments.

## CANCELLATION & MISSED APPOINTMENT POLICY

I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments. **Please note: Repeated "missed appointments" may result in discharge from the practice.**

**PATIENT SIGNATURE**

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## 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.**

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 1, 2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**Other Uses and Disclosures of PHI:**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights:

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective August 2016

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

# VAUGHN FAMILY DENTAL

## 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, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS. WE ALSO OFFER **CARE CREDIT** WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

## Regarding Insurance

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. 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.

## Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

## Adult Patients

Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when you arrive for your appointment.

## Minor Patients

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 time of service has been verified.

## Payment Plans

Vaughn Family Dentistry has partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 3, 6, or 12 months with approval. No other payment plans are available.

## Billing

All accounts which have not paid the estimated portion of their bill at the time of service will incur a \$3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a \$30 returned check fee.

## Refunds

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

## Collections

Any account that has not received payment in **60 days** will be handed 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.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy. This copy is for your records, please sign the signature pad at the front desk.

Signature\_\_\_\_\_

Date\_\_\_\_\_