WEST ARVADA
FAMILY DENTAL

Patient Information

Today's Date: _____

Name:_____ Preferred Name: _____

DOB:_____SSN: _____

Address:_____City_____Zip _____

Cell Phone Number_____ Work Number_____

Email: _____

Employer: _____

Parent of Guardian if Under 18: _____

Emergency Contact Relationship _____

Emergency Contact Phone Number_____

How Did You Hear About Us

The Information I have given today is correct to the best of my knowledge.

I understand that I must inform this office of any changes to my contact info and medical status.

HIPAA Compliance Patient Consent Form

Patient Name:_____

Responsible Party Name: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Financial Agreement

Patient:_____

DOB: _____

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy. We offer the following methods of payment:

- Payment in full is due at the time of service. Cash, Check, Debit Card, MasterCard, Visa, Discover and American Express accepted.
- For patients with insurance, we will accept payment directly from the insurance company, but require that the deductible and non-covered fees be paid at each visit.
- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for child's co–payment.
- We offer a Dental Discount Plan to patients without insurance. If you are interested in more information, please contact the front desk.
- For your convenience, we provide patients with the option to authorize the use of their credit card. These authorizations allow Summit Dental Group to charge a patient's credit card for unpaid copays or account balances in our office without your presence but only after your consent. Important Information Regarding Your Dental Benefits.
- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
    - Not all dental services are a covered benefit in all contracts. It is your responsibility to know your benefits.
    - You (not the insurance company) are responsible to us for all our fees for services rendered to you. An ESTIMATE will be given of the benefits that the insurance company is expected to pay. Remember that this is only an ESTIMATE and that the actual cost may vary.
    - BROKEN/MISSED APPOINTMENT: Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for you convenience and hold great value. We require 48-hour notice of canceling or rescheduling your appointment, if 48 hours' notice is not given a $75.00 fee will be charged. I acknowledge I have received and agreed to West Arvada Family Dental's Payment & Financial Policies.

Consent to receive electronic communications

We know you are busy. Let us help by sending automated reminders and more. Our office is now able to send email and text messages to patients to confirm appointments, let you know of upcoming events, and provide additional communication notifications! This is a great tool to utilize when a phone call isn't possible. However, we understand that some patients prefer to be called.

Please indicate if you would like to receive email and text message appointment confirmation and reminders, newsletters, marketing material, account updates and opportunities to provide feedback.

We may also use your information for direct and indirect marketing, including audience targeting.

You can withdraw your consent to receive electronic communications at any time by calling our office. Please note that you are responsible for providing our office with any updates to your email address and/or cell phone number.

Email:

Patient Treatment Consent- Initial Visit

- I authorize the dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the dentist. The form also authorizes this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "signature on file". I authorize my dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- Patients who have dental insurance should be aware that dental services are rendered and charged to the patient, not the insurance company. our secretary will be pleased to assist you in making your dental insurance claims by completing an attending dentist's statement for submission to your insurance company.
- I have also received a copy of this office's notice of privacy practices. I am giving my consent to use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature of Patient or Responsible Party:_____Date:_____