Patient Information

Patient Name: _____ Gender: _____
Last, First MI (Preferred Name)

Cell Phone: _____ Social Security No. _____

Email address: _____ Date of Birth: _____

Work Phone: _____ Family Status: Dependent / Single / Married

Home Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend / relative / coworker ☐ Physician/Dentist

☐ Yellow Pages ☐ Internet search ☐ Insurance website ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ _____
_____

Medication: List all medications you are currently taking.

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Cellular): _____ (Work): _____ Ext: _____

Address: _____
Street City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Financial Policy

Welcome to Today's Smile. Our goal is to provide you with the highest quality dental care and customer service in a friendly atmosphere. The following is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Deductibles / Co-Pays / Services not covered by your insurance company: It is the patient or the patient's guardian responsibility and it is our policy that they are paid at the time of service. We accept cash, credit/debit cards (Visa, MasterCard, & Discover), and checks. In the event a check returns to us due to insufficient funds, there will be a $25 charge for each returned check(s). In cases where you have overpaid us due to insurance benefit estimation error, we will issue a refund check if it is greater than $20. If it is under $20, then we will leave the money in your account as a credit unless you request for a refund check.

Collections: If you are left with a balance on your account you will be billed. Payment is expected within 30 days. It is our policy that after 90 days of billing you for your balance without payment or response from you, your account will automatically be turned over to an outside collection agency and may be subject to legal action. If your account is sent to a collection agency, 50% of your account balance will be added to your outstanding balance.

Correct Information: It is critical we have the correct insurance information. If we do not have the correct information, your claim may be denied or not submitted in the allowed amount of time and the entre balance will become your responsibility. If you are providing insurance coverage for a dependent, who is covered under the student policy provision, you are responsible for providing the insurance company updated information for each semester your dependent is covered. If a claim for a dependent is denied under a validation provision, the entire balance and collection of any insurance payments will become your responsibility. We do not resubmit for any of the above-mentioned claims.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. YOU ARE RESPONSIBLE FOR YOUR OWN ACCOUNT BALANCE WHEN YOUR INSURANCE COMPANY DOES NOT PAY YOUR CLAIMS. It is your responsibility to know your insurance policy, its rules, limitations, and exclusions. it is your responsibility to communicate your insurance company to help facilitate payment or any problems with denials.

If your insurance has not paid within 30 days our system automatically generates a new claim and submits it on your behalf. Insurance Companies are required to pay claims within 30 days under the Maryland Insurance Prompt Pay Statue. If your insurance does not pay within 60 days, the entire balance is automatically transferred to become the patient's responsibility.

We value each and every patient and it is our privilege to provide care to you and your family. This policy allows us to spend more time with you rather than correcting problems that often arise with insurance issues. We sincerely thank you for choosing our practice for your dental care, and we will do our best to provide you with best possible dental care and best customer service.

Patient (or Guardian) Signature: _____ Date: _____

Patient Printed Name: _____

TODAY'S SMILE LLC
Cosmetic & Implant Dentistry
Stanley Park, DDS

To: Our Patients

Did you know we are averaging **30 or more missed appointments per week?** This not only affects the quality of care that we provide, but makes scheduling prompt and convenient appointment times for both existing and new patients incredibly difficult.

We find ourselves in an unenviable position of having to manage this problem without inflaming the delicate relationship we have with our patients.

With that in mind, we ask that you kindly give us 24-hour notice if you need to cancel or reschedule your appointment. Canceling an appointment at the end of the day for the next day or canceling over the weekend for a Monday appointment will be treated as a non-24-hour notice. We also would like to ask our patients to be mindful of the fact that our reminder service which may be a phone call or an email is strictly a courtesy call. There may be times where the reminder system is unable to reach you, therefore please do **NOT** rely on this service alone.

If an appointment is broken without 24 hours advance notice, a broken appointment fee will be applied and become due as part of your account balance. This fee is not covered by your insurance and will need to be satisfied prior to rescheduling future appointments.

If you do not give our office the advance notice that you will be unable to make your scheduled appointment time, you may be responsible for payment of the following:

The First missed appointment	$45.00 charge/half hour
The Second missed appointment	$65.00 charge/half hour
The Third missed appointment	$ Full fee of appointment
Surgical appointment	$ Full fee of appointment

Thank you in advance for your cooperation in this matter.

I have read and understand the statement noted above.

Patient (or Guardian) Signature: _____ Date: _____

Patient Printed Name: _____

10025 Governor Warfield Pkwy, Suite 218, Columbia, MD 21044 • www.TodaysSmileDental.com
Tel: 410-997-8383 • Fax: 410-997-8434 • Email: TodaysSmileDental@verizon.net

Today's Smile, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I,_____ (the "patient" or "patient's legal representative"), have been presented with Notice of Privacy Policy of Today's Smile, LLC., and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____[Please initial here] I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide to me

_____

Signature of Patient Date

For Office Use Only

I,_____ [Please print full legal name here], acting as Patient Coordinator for Provider attempted to obtain the written acknowledgment of receipt of the Policy of provider on _____[Please insert date attempt was made], but acknowledgment could not be obtained because:

_____ [Please initial here] Patient of Patient's legal representative refused to sign.

_____ [Please initial here] Patient of Patient's legal representative could not be communicated with sufficient to obtain acknowledgment.

_____ [Please initial here] Emergency circumstances prevented securing acknowledgment.

_____ [Please initial here] Other (Please specify)

_____

Signature of Provider Representative Date

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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.

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 (MM/DD/YR), 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 us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and 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.

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 with your healthcare or with payment for your healthcare, but only if you agree 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 a 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 institution or law enforcement official 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 voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: *You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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, but not before April 14, 2003. 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.

Restriction: 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 explain 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 AND 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 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.

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