Thorne Family Dentistry

**HIPPA Consent Form**

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. The safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). The restrictions do not include the normal interchange of information necessary to provide you and your family with treatment. HIPPA provides certain rights and protections to you as the patient. We must balance these needs with our goal to providing you with quality service and care. For this reason, our practice has adopted the following policies:

(1) Patient Information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

(2) It is the policy of this office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

(3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPPA.

(4) The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or Insurance companies in the normal performance of their duties.

(5) The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

(6) Your confidential information will not be used for the purpose of advertising or marketing of products, goods or services. Such prohibition does not include treatment, product samples or goods of normal value.

(7) The practice agrees to provide the patient with access to their records in accordance with state law.

(8) The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient

I,_____ do here by agree to the terms set forth above and any subsequent
Patient or Guardian

changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

_____

(patient signature) (date)

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## PAYMENT OPTIONS

- CASH
- CHECK
- MAJOR CREDIT CARDS, VISA, MASTER CARD, DISCOVER
- PATIENT PAYMENT PLANS THROUGH CARE CREDIT, CAPITAL ONE. NO INTEREST OR EXTENDED PAYMENT PLANS, WHICH OUR OFFICE CAN GIVE YOU MORE INFORMATION

## PATIENTS WITHOUT DENTAL INSURANCE

OUR OFFICE POLICY REQUIRES THAT PAYMENT IS DUE IN FULL ON DATE OF SERVICE

## PATIENTS WITH DENTAL INSURANCE

I. WE WILL FILE YOUR INSURANCE AS A COURTESY TO YOU, BUT WE DO EXPECT YOUR ESTIMATED PAYMENT AND DEDUCTIBLE TO BE PAID AT THE TIME OF SERVICE. THE TOTAL FEE IS ULTIMATELY THE PATIENT'S RESPONSIBILITY.

2. THE ESTIMATED CO-PAYMENT IS MERELY AN ESTIMATE AND NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY.

3. YOU MUST PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR INSURANCE COMPANY IN ORDER FOR US TO SUBMIT A CLAIM FORM. IF NOT PROVIDED, YOU WILL BE REQUIRED TO PAY FOR YOUR VISIT IN FULL AND LET YOUR INSURANCE COMPANY REIMBURSE YOU.

**THERE WILL BE A $25.00 CHARGE ON ALL RETURNED CHECKS. THERE WILL ALSO BE A $50.00 CHARGE ON APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS PRIOR TO APPOINTMENT.

*SIGNIFICANT COSTS ARE INCURRED IN CARRYING OUR PATIENT'S ACCOUNTS. TO CONTROL THESE COST AND HELP KEEP FEES DOWN, IT IS NECESSARY TO ADHERE TO THIS FINANCIAL POLICY.*

**I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY INSURANCE BENEFIT PLAN. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION REGARDING MY DENTAL CARE. I HEREBY AUTHORIZE PAYMENT OF MY DENTAL BENEFITS TO THORNE FAMILY DENTISTRY.**

SIGNATURE _____ DATE _____

PRINT NAME _____

Thorne Family Dentistry

# Communication Preference Form

Patients Name: _____

Please check **all** that you prefer:

Email: ☐ _____
Text: ☐ _____
Cell: ☐ _____
Home: ☐ _____
Work: ☐ _____
Other: ☐ _____

**Please let us know which form(s) of communication you would prefer.** We are offering different methods of communication as listed above as a convenience and courtesy to our patients. Your Privacy is of highest priority; therefore this information is only used by our office for reminders, newsletters, confirmations, **etc.** If at any time you have a change or want to cancel, you may do so.

Thank You,

Thorne Family Dentistry

Thorne Family Dentistry

Chart #:_____
FOR OFFICE USE ONLY

## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #:_____ Birth Date:_____

Phone (Home): _____ (Cell):_____ (Work):_____ Ext:_____

E-Mail address:_____ Best way of contact (Phone # or email)_____

Address: _____
Street Apartment #

_____
City State Zip

EMERGENCY CONTACT NAME: phone#

## 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
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
Ulcers
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnant now?_____
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
Do you smoke?
How much?_____
Drink alcohol?
How often?_____
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐_____
☐ _____

- 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

## Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

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

## 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 (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

## Employment/Insurance Information

Primary Insurance Information

Name of Insured: _____ DOB: _____ SS# _____

Employer: _____

Insurance Company: _____ Group#: _____

Insurance Address _____

Street City State Zip Code

Insurance Phone #: _____

Secondary Insurance Information

Name of Insured: _____ DOB: _____ SS# _____

Employer: _____

Insurance Company: _____ Group#: _____

Insurance Address _____

Street City State Zip Code

Insurance Phone #: _____

## Medications List

_____

_____

_____

_____

## 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 also give my permission for this office to photograph my person/oral cavity for educational and/or record purposes.

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