1447 Dental Associates
1447 E Market St, York, PA 17403, USA
(717) 845 2771
www.1447dental.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Contact Information

Work phone number	

Patient's signature: _____ Date: _____

PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 1447 E Market St, York, PA 17403, USA:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: _____ Date: _____

FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered 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. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care. Our goal is to help you afford your dental choices.

At the onset of treatment, we will provide you with an *estimate* of your total treatment costs. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options that we offer.

INSURANCE:

As an unrestricted provider, we are able to treat both patients without insurance as well as patients with insurances that allow them to choose their preferred provider. For those patients with dental insurance, our goal is to help you maximize your dental benefits. As a courtesy, we are happy to bill your dental plan for services rendered as well as provide pre-treatment estimates at your request. However, please remember your insurance policy is a contract between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. Any balance is your responsibility whether or not your insurance company pays any portion.

Please remember, dental benefit plans are not designed to cover all of your dental needs; rather, the amount your plan contributes towards your dental care is based on the plan selected and purchased by your **employer**.

PAYMENT:

- **OPTION 1:** Payment in full on the day of each visit. To demonstrate our appreciation for patients who are prompt with full payment, we will extend a five percent (5%) reduction of the fee totaling $500.00 or more. If you have a dental plan, the reduction is taken from your estimated co-pay only.
- **OPTION 2:** You may use your credit or debit card to make payment (both in office or online). We gladly accept MasterCard, Discover, or Visa. When using this form of payment, we do not offer the five percent (5%) reduction in fee.
- **OPTION 3:** We are pleased to offer our patients another extended monthly payment plan option through a dental financing company, Care Credit. Please see our front desk prior to treatment for more details and to receive a loan application.

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%) at the discretion of the practice. If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, the practice reserves the right to charge a fee of

$50. Please help us maintain the highest quality of care for you, and all of our patients, by keeping scheduled appointments.

Again, feel free to contact any member of our team if you have any questions regarding the payment options described above. We thank you for trusting us with your dental care needs and hope that you will let us know if we can improve our service to you in any way.

I accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: _____ Date: _____

COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. 1447 Dental Associates offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. 1447 Dental Associates will use reasonable means to protect the security and confidentiality of email information sent and received. However, 1447 Dental Associates cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between 1447 Dental Associates and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by 1447 Dental Associates.

Patient's signature: _____ Date: _____

TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. 1447 Dental Associates, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. 1447 Dental Associates will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, 1447 Dental Associates cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between 1447 Dental Associates and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by 1447 Dental Associates.

Patient's signature: _____ Date: _____