Receipt of Treatment Plan and Financial Policy

1. Payment , Insurance and Financial Arrangement Policies(must be signed by ALL new patients)

By signing below, I acknowledge that I received the financial policies form and agree to abide by such policies.

Signature: _____ Date: _____

(If the patient is a minor or disabled, the parent, Guardian or Attorney-In-Fact must sign above and complete Responsible Party section below)

2. Privacy Notice Practices (must be signed by ALL new patients).

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by Health Insurance Portability and Accountability Act of 1996 ("HIPPA")

Signature: _____ Date: _____

(If the patient is a minor or disabled, the parent, Guardian or Attorney-In-Fact must sign above and complete Responsible Party section below)

3. Release of information to insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent to my practices (or their designees) use and disclose of my Protected Health Information to carry out payment activities in connection with my insurance claim. I understand that my dental office is not required to file a dental claim but that it is a courtesy of the office to do so. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of dental benefits otherwise payable to me.

Signature: _____ Date: _____

Responsible Party (If patient is under 18 or disabled)

Circle One: Dr. / Mr. / Mrs. / Ms. / Miss.

First: _____ Middle: _____ Last: _____Jr/Sr.

Street: _____ City: _____ State: _____ Zip: _____

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

Responsible Party Social Security: _____ -___-_____ Date of Birth: _____/_____/_____

Signature: _____ Date: _____

Financial Agreement

Our goal is to provide the highest quality of dental care possible and have clear communication of our financial policy.

All ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment Options:

1. Cash
2. Check
3. MasterCard/Visa
4. Care Credit
5. Credit card authorization for recurring charges:
    a) **Treatment that exceeds $275**
    b) **Plan may not exceed 4 months**

Patient with insurance: **THE PATIENT** is responsible for the **ESTIMATED** non-covered portion, procedures and/or deductible at the time of service. Or the patient can sign a credit card authorization to bill the credit card AFTER the insurance has paid for the visit. If the insurance company doesn't pay after 60 days then we will bill directly. If the balance continues to be unpaid for 90 days then the account will be sent to collections.

- Parents not accompanying their child to their appointment must make prior arrangements for payment (cash, check or credit card authorization).
- Parents accompanying their children are financially responsible for payment.
- 18% annual interest is charged for any un-paid balance. $15 fee for non-payment.
- There is $35 processing charge for non-sufficient funds or returned checks.
- Records can be viewed at any time. There is nominal fee for release or copies of records.
- Because Instruments, chairs, and personnel are reserved exclusively for your appointment, **there is a $25-$50 CHARGE FOR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, _____, agree to the financial terms

Signature: _____ Date: _____

Consent for Photography and Radiographs

I, _____ (patient) Authorize the Dentist (Sandy Michelet-Vialva, DMD) to take photographs and/or radiographs of my teeth before, during and after treatment for insurance purposes only.

I consent to allow the photographs to be used for the following:

- Dental Records
- Insurance Claims

I understand that if I refuse to take x-rays and intra-oral photos that it may result in denial of the claim and I will be held responsible for the total cost of treatment rendered at that time. My signature signifies that I have read and understand the consent forms.

_____ Date: _____

Signature of Patient

1755 Parker Road SE, Suite A110

Conyers, Georgia 30094

Appointment and Cancellation Policy

When we make appointment, we are reserving a room for your particular needs. We ask that if you must change your appointment, please give us at least 24 hour notice. **Leaving a voicemail message after hours is not acceptable, you must speak with a staff member in order to cancel or reschedule an appointment**. This courtesy makes it possible to give your reserved room to another patient.

There is a charge of $25.00-$50.00 for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges and/or dismissal from the office.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared and special instruments are readied for you visit. Except for Emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

I have read and do understand the policy of the office. By signing this document, I am agreeing to the policies of the office.

_____

Printed Name of Patient

_____

Signature of Patient/Guardian if patient is under 18 years of age

_____

Date

Credit Charges

We really do Value ALL of our Customers….

In fact, that's the primary reason we have decided to price all our goods and services with a Cash Discount payment option. The cost of accepting electronic payments contributes to rise, often on a monthly basis. More customers than ever pay with credit cards and many of them are "rewards" cards. Most consumers don't understand that our business ultimately funds those valuable rewards points. As a result, our cost of doing business continues to increase. Up to a point, we have absorbed all price increases internally. However, in effort to keep our prices competitive and our business profitable, we have decided to price all our goods and services with a cash discount. Meaning you will pay what is discussed without paying extra fee(s) from a credit/debit card machine charge. We still welcome various electronic payment methods in our business. However, those transactions will incur non-cash adjustments to help offset the fees we must pay to process those payments.

Again, we value ALL of our customers and we understand some patrons may not agree with our position, but we take this position in order to provide better services as well as more value in the future.

Thank you very much for your understanding and continued loyalty.

I have read and understand that Signature Family Dentistry has made me aware of the charges and financial agreement. By signing this document, I agree with the charges and many payment options offered for my dental treatment.

_____Date of Birth: _____

Patient's Printed Name

_____ Date: _____

Patient's/Guardian (If patient is under 18 years of Age) Signature

COVID-19 Emergency Dental Questionnaire

Patient's Name: _____ Date Of birth: _____

Temperature: _____ (taken by staff member): _____

I, _____, knowingly and willingly consent to have emergency dental treatment completed during the **COVID-19** pandemic. I understand the **COVID-19** virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not give the current limits in virus testing. Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the **COVID-19** virus.

I have been made aware of the **CDC** and **ADA** guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. _____ **(Initial)**

I confirm I am seeking treatment for a condition that meets these criteria. _____ **(Initial)**

I confirm that I am not presenting any of the following symptoms of **COVID-19** listed below:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat

_____ (Initial) I understand that air travel significantly increases my risk of contracting and transmitting the **COVID-19** virus. And the **CDC** recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ **(Initial)**

I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by **COVID-19.** _____ **(Initial)**

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ **(Initial)**

1. What are your current medications? Please list All Medications, dosages and frequency in which you take them:

   Medication: _____ Condition: _____

   Medication: _____ Condition: _____

   Medication: _____ Condition: _____

I have read and understand that these questions are necessary to prevent and reduce the spread of **COVID-19**. I understand that Signature Family Dentistry is taking necessary precautions for my well-being as well as the staff. I have answered the questions honestly and truthfully. If for some reason I was not forth coming or at all honest with to my dental provider with my responses. I can be dismissed from the practice and will need to seek dental treatment with another dental office. I acknowledge this by signing below.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	**SOCIAL SECURITY NUMBER**	**HOME PHONE** ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	Drivers License and State

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

Responsible Party

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? _____

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon

❑ Other _____ ❑ TV/Radio Ad ❑ Newspaper Ad ❑ Direct Mailing ❑ Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

•I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

Signed _____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist_____ Last Visit_____ Date of last cleaning_____

Reasons for changing dentists:_____

What problems have you had with past dental treatment?_____

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:_____

How often do you brush?_____ Do you floss? ❑ Yes ❑ No How often?_____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?_____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? *please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3 .Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?_____ How many years?_____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year_____Type of operation:_____Year_____Type of operation:_____
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____.
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction

Doctor Notes Only:

36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

21. Y N Do you have any other medical problem or medical history NOT listed on this form?_____

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?_____

Please list all medications you are currently taking:

Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Physician's Name_____Phone_____
Address_____ Fax _____

In the event of an emergency please contact:

Name_____Relationship_____Phone _____
Name_____Relationship_____Phone _____

Initial medical/dental health reviewed by:

X_____ / ____/____ X_____ / ____/____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X_____ / ____/____ X_____ / ____/____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT