Tooth Berry Kids DENTAL

Patient Information

Date_____

Patient's Name:_____DOB:_____
Last First MI

Address: _____
Street City Zip Code

Home Phone:_____Cell Phone:_____SSN:_____

Whom may we thank for referring you to our office?:_____

Responsible Party Information

Name:_____Relationship:_____
Last First MI

Mailing Address:_____
Street City Zip Code

Home Phone:_____Cell Phone:_____Work#:_____

Employer:_____Occupation:_____Ssn:_____Dob:_____

Spouse's Name:_____ Relationship to Patient:_____

Employer:_____Occupation:_____Ssn:_____Dob_____

Dental Insurance Information

Primary

Insured's Name:_____ ID#:_____

Insurance Company:_____Group #:_____

Do you have Dual Insurance **YES** **NO** If Yes:

Secondary

Insured's Name:_____ID#:_____

Insurance Company:_____Group #:_____

Emergency Contact

Name of nearest relative not living with you:_____
Last First MI

Mailing Address:_____
Street City Zip Code

Home Phone:_____Cell Phone:_____

Tooth Berry Kids DENTAL

Welcome to Tooth Berry Kids Dental

Dear Patient,

The Doctors and Staff would like to take this time and welcome you to our practice. We thought you might like to know a little more about our policies and how committed we are to achieve patient satisfaction.

We would like to go over some of our policies before you are seen:

1. We require a **48 hour notice** for any cancelations. This time is specially for you. Any change in the schedule affects many people.
2. There is a $35 return check fee. If payment is made by check, verification of funds will apply.
3. If you have insurance we ask that you pay your estimated portion on the day of your appointment.
4. If you do not have insurance we ask that you pay for services on that day in full (we accept Check, Visa, and MasterCard). If this poses a hardship, we will work with you to develop an alternative financial agreement.
5. We do also accept Care Credit, We will be happy to help you apply.

Tooth Berry Kids Dental reserves the right to reschedule your appointment if you are more than 10 minutes late. We will do our best to accommodate you, however it is not a guarantee your child will be seen if they arrive late. We understand your time is important and we kindly ask if you could please respect the time we have reserved for your child and arrive on time for your appointment.
If patients miss three or more scheduled appointments, Tooth Berry Kids Dental will no longer be able to see the patient in our office.

At Tooth Berry Kids we believe every child needs one hundred percent un-divided attention and in order to provide excellent care, we block off a certain time slot specifically for the patient, if the patient fails to attend, it increases the wait time for other patients who would like to be seen sooner.

Thank you for understanding and helping us by abiding by these rules in our office. Should you have any further questions, please do not hesitate to ask the front desk.

_____ _____

Patient's name Parent/Legal Guardian signature Date

HIPAA

Patient's Rights: 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 health information. 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 use and disclose health information about your for treatment, payment, and healthcare operations. For example, we may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

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 disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Unless you give us 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, only if you agree that we may do so.

Person 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're present, then prior to use or disclosures 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related services: We will not use your health information for marketing communications without your written authorization.

As required by Law: We may use or disclose your health information when we are required to do so by Law.

_____ _____

Patient's Name Parent/Legal Guardian Siganture Date

AGREEMENT

We work hard to provide care at a considerable cost savings to you. We do this by offering our services and agreeing to accept your insurance as full or partial payment, provided that you chose to comply with the agreement below.

Please read and sign the following:

I hereby agree that if I am not eligible for dental Insurance, or if the dental procedures performed are not paid by my dental insurance, I will be responsible for all charges incurred.

Unlike most professional offices, we do not require you to pay in advance for your services, unless prearranged copayments are required. We can only do so if you agree to provide payment in accordance with the terms of the Agreement. We appreciate the opportunity you have given us to provide care to you and we work hard to make our professional care available at a cost savings.

The undersigned here by authorizes and direct any voluntary plan carrier, or group insurance benefit carrier to pay directly to Tooth Berry Kids Dental expense benefits, otherwise payable to me, that I or my family are entitled. I understand that I am responsible for charges not covered by the authorization.

I certify that this information was presented to me and that I have read and understand its consents. I have had the opportunity to discuss my dental coverage to clarify any areas I did not understand.

_____ _____

Patient/Parent/Guardian Signature Date