Mount Vernon Smile Design
219 N 10th St, Mt Vernon, WA 98273
(360) 336 6193
www.mvsmiledesign.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: | |

Patient's signature: Date:

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# PATIENT INFORMED CONSENT

We are pleased that you have chosen Mount Vernon Smile Design to be your oral health care provider. In order for us to provide optimal treatment, it is necessary for you to understand the types of treatment provided in our office, the fees for the treatment, and follow-up care. Please take a few moments to read this consent for treatment as it may clarify important questions/issues that may come up during treatment.

CONSENT TO DENTAL PROCEDURES As a patient, you will have access to information about your condition and will be eligible, unless otherwise specified, to receive continuity of treatment, which may include treatment provided by multiple dentists, be provided with estimate of the cost, and receive dental care according to a sequenced plan of treatment. Before receiving treatment you should ask the dentist or assistant about the procedure(s) recommended for you, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X-RAYS Dental radiographic images will be made as necessary and appropriate for examinations, diagnosis, consultation and treatment. It is the dentist's sole discretion for what x-rays are necessary for appropriate treatment.

FINANCIAL RESPONSIBILITY You will be charged for treatment according to the fee schedule in effect at the time of treatment. A fee estimate will be provided prior to beginning treatment and you must be prepared to pay for services as they are performed. Fees are collected in full at the end of the procedure unless other arrangements are made in writing. If for some reason you do not pay in full for the treatment provided that day, any balance remaining on your account 90 days after treatment will result in your account being turned over to a collection agency.

DENTAL INSURANCE Mount Vernon Smile Design participates with several dental insurance companies. The office will do it's best to offer accurate estimates with insurance coverage but will not be held responsible for procedures not covered by your specific plan. These are just estimates and it is your responsibility to pay the full amount of your bill if a procedure is not covered by your insurance, your insurance company is no longer in network with our office, etc. It is your responsibility to provide accurate insurance information to our office and to cover the cost of any uncovered dental procedures and to know if your particular plan is in network with our office.

DENTAL MEDICAL RECORDS The dental medical record, radiographic images, photographs, videos, models and other diagnostic aids relating to your treatment are the property of Mount Vernon Smile Design. You have the right to inspect such materials and to request a copy of your dental medical records and radiographic images. A
fee may be required for copying such items. You may also request to have your dental radiographs sent to another health care provider by signing a Release of Information form. Mount Vernon Smile Design complies with requirements of the Health Insurance Portability and Accountability Act (HIPPA) and will only share information with those on your family file. You will receive separate information, forms, and consents in that regard. In addition, your dental medical record may be used for instructional purposes.

KEEPING YOUR APPOINTMENT It is important for you to be on time for your appointments. If you find that you are unable to keep an appointment you agree to notify the office at least 48 hours in advance. A total of three cancelations without 48 hour notice, more than two missed appointments, or repeated unsuccessful attempts to arrange an appointment may result in the discontinuance of further treatment at our office and fees.

TEXT USAGE FOR APPOINTMENT REMINDERS Text messages will be used for appointment reminders and other healthcare communications at the number you have provided our practice. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. You have the right to opt out of text messages at any time.

DISCONTINUANCE OF TREATMENT Mount Vernon Smile Design reserves the right to discontinue treatment in its sole discretion. Should treatment be terminated, any remaining credit balance for services not yet provided will be refunded to you.

I hereby acknowledge that a licensed dentist and/or office staff has explained to me the nature of the treatment, the risks and potential benefit, the availability of alternative methods of treatment, and the risks of no treatment. I hereby acknowledge, agree, and give my voluntary consent for treatment provided by Mount Vernon Smile Design. This Authorization includes but is not limited to, routine diagnostic procedures, outpatient care, laboratory tests, and x-rays. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment received at Mount Vernon Smile Design. I acknowledge that my care is under the direction of my treating professional(s) and I present that I will follow the instructions of my professional(s) regarding care and treatment.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have a received a copy if you want, and that you accept dental care and treatment under the described terms and conditions.

Patient's signature: Date:

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# 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 provider at the following address (insert address of provider):

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 my 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 separate from the rest of the client's 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 individual's 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 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 individual's 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:

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# 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.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

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.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney’s 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, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

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

Patient's signature: Date:

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# 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. Mount Vernon Smile Design 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. Mount Vernon Smile Design will use reasonable means to protect the security and confidentiality of email information sent and received. However, Mount Vernon Smile Design 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 Mount Vernon Smile Design and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Mount Vernon Smile Design.

Patient's signature: Date:

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# 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. Mount Vernon Smile Design, 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. Mount Vernon Smile Design will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Mount Vernon Smile Design 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 Mount Vernon Smile Design and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Mount Vernon Smile Design.

Patient's signature: Date: