Villa Rica
FAMILY DENTAL

Office Policies and Financial Guidelines

In order for us to provide higher quality dental ca re in a relaxed environment, we want you to understand our office policies. If you have any questions, please do not hesitate to ask.

We are committed to the success of your treatment, and we charge what is usual and customary for our area. Payment is expected at the time of service unless other arrangements have been made in advance. We accept cash, Visa, MasterCard, and we offer financing plans. If you are interested in financing treatment, please ask our front office staff for details.

We manage our schedule so that we can provide individualized attention to each patient. This means that your appointment time is reserved exclusively for you, and we are counting on you to be here. We realize that your time is valuable, and we will do our best to respect your time by being ready for you at your appointment time. **If you will not be able to make a scheduled appointment, we need at least 24 hours notice so that we can fill your appointment time with another patient. After (1) broken appointment, computer will automatically inactivate your chart. In order to reactivate your chart and to schedule another appointment, $50 must be paid.**

To help ensure that you cancel within the needed time frame, it is our policy to call you to confirm your dental appointment 2 days before it is scheduled. **If you're not there to answer the phone and a message is left asking you to call back and confirm, please be sure to do so.** If you receive the message after office hours, please call the office number and leave your confirmation on the voice mail. **If we do not hear back from you within the appropriate time frame, the appointment may be given to someone on our waiting list. If the appointment cannot be confirmed due to the phone number being changed or disconnected, it will be cancelled unless you contact us.**

For safety and liability reasons, only the patient may be present in the room during treatment. This allows the doctor and the clinical team to focus full attention on the patient. Allowing a child in the room while the patient is being seen puts the child at risk of injury from sharp instruments and chemicals present in the room. For the safety of their children, parents who bring young children should provide adult supervision in the reception room while the parent is in the back. Likewise, we ask that parents wait in the reception room while their children are being treated. We will not hesitate to call parents back when necessary, and all findings will be reviewed with the parent.

Payment is due at the time of services rendered, and we will gladly give you an estimate for each appointment. If you have dental insurance or are a Medicaid or Peachcare patient, please be sure to bring your card to your first appointment. For those patients with dental insurance, we will make every effort to help you maximize the benefits available from your plan. We will be happy to assist you by submitting claim forms to your insurance company.

Please understand that we deal with many different insurance plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the unique requirements of each and every plan. Your plan may have limitations on the number of visits, x-rays and procedures considered for payment. If you have any questions about whether a procedure will be considered for payment, please contact your insurance carrier before beginning the procedure. **The deductible, your percentage, and any outstanding balance not paid by insurance must be paid by the patient.**

In order to keep our fees reasonable, we cannot extend patient accounts beyond 60 days. A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. At 90 days, we ask that you pay the balance or transfer the balance to our financing company. We will provide all the documentation necessary for you to collect payment from the insurance company. In the rare event that it is necessary to turn your account over to our collections agency, you will be responsible for additional collection fees.

Please be sure to let us know as soon as possible of any address change, insurance coverage, or change in your medical history. We are here to serve you and want to make your visit to or office a pleasant one.

We hope that you will never experience a dental emergency. However, if you do, we will be here to help you. If your emergency occurs during office hours, please call immediately so that we can schedule a time for you. After office hours, please call the office number and leave a message on our voice mail. Dr. Chang will be notified and we will return your call.

Signature _____

Villa Rica
FAMILY DENTAL

Patient Information

Date _____ How did you hear about our office? _____

Patient _____
Last Name First Name MI Preferred Name

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Cell/Other Phone _____ Social Security # _____

Email Address _____ Best phone # to confirm appointment: Home Work Cell

Sex _____ Age _____ Birthdate _____ Marital Status: Single Married Other

Employer _____ Occupation _____

Name of person responsible for account _____

If you have insurance, please complete this section.

Dental Insurance Company _____ Group Number _____

Policyholder's Name _____ Relationship to patient _____

Policyholder's Address _____

_____

Policyholder's Employer _____ Policyholder's Work Phone _____

Policyholder's SSN _____ Policyholder's Birthdate _____

Please read and sign below.

Assignment / Release:

I, the undersigned, assign directly to Dr. Jamey Chang/Villa Rica Family Dental PC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Dr. Jamey Chang to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

Minor / Child Consent:

I, being the parent or guardian of the patient listed above, do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of fluoride, local anesthetics or nitrous oxide as deemed advisable by Dr. Jamey Chang, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____ Signature _____

Villa Rica
FAMILY DENTAL

Patient Health History

Are you currently under the care of a physician? ____ Yes ____ No If yes, for what conditions? _____

Are you taking any prescription or over-the-counter medications? ___ Yes ___ No If yes, please list:_____

_____ Do you smoke? ___ Yes ___ No

Women: Are you pregnant? ____ Yes ____ No Are you nursing? ____ Yes ____ No Taking birth control pills? ____ Yes ____ No

Do you have any drug allergies? ____ Yes ____ No If yes, please list: _____

Adverse reaction any drugs? _____ Yes _____ No If yes, please explain: _____

Do you currently, or have you ever had any of the following? (Please check all that apply.)

____ High Blood Pressure
____ Low Blood Pressure
____ Heart Attack
____ Take aspirin regularly
____ Circulatory Problems
____ Respiratory Problems
____ Asthma
____ Kidney Disorders
____ Hepatitis or Liver Disease
____ Epilepsy/Seizures
____ Bleeding Disorders
____ Stomach Ulcers
____ HIV / AIDS or other immune disorder
____ History or chemical dependency
____ Stroke
____ Diabetes
____ Cancer
____ Radiation Treatment
____ Psychiatric Care
____ Back Problems
____ Arthritis

The following questions relate to the need for the antibiotic prophylaxis to prevent a potentially serious infection.

Have you ever been advised to premedicate (take an antibiotic) before dental appointments? ____ Yes ____ No

____ Congenital heart defect
____ Artificial heart valves
____ Joint replacement
____ Artificial joints
____ Rheumatic fever
____ Previous bacterial endocarditis

If you have had any of the above conditions, but you know that you are not required to premedicate, we will require a letter from your physician verifying you do not need to premedicate.

Please list anything else we should know about your medical history: _____

_____

Do you have any of the following dental conditions? (Please check all that apply.)

____ Periodontal/Gum Disease
____ Bleeding when brushing or flossing
____ Sores or lumps in or near mouth
____ Head, Neck or Jaw Injuries
____ Clenching or grinding your teeth
____ Clicking, popping or pain in jaw joint
____ Bad Breath
____ Sensitivity to cold or sweets

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my dental treatment and/or my overall health. I will not hold Dr. Jamey Chang or her staff responsible for the results of any errors or omissions in the information I have provided on this form.

I have read and understand the Office Policies and Financial Guidelines provided to me, and all my questions have been answered to my satisfaction. I understand that payment is due at the time of service unless other arrangements have been made in advance. I will accept responsibility for all charges not paid by my insurance within 60 days of my visit.

I have read the privacy practices of this office. I have been given a copy of this notice. All my questions about the privacy of my health information have been answered to my satisfaction.

Date _____ Signature _____

Villa Rica
FAMILY DENTAL

Privacy Practices

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to explain to you the ways in which we will use and disclose the information about your health that we obtain in the course of your treatment. The privacy of your health information is very important to us, and we will use that information only in ways that we feel are beneficial to your health. Besides using your information to treat you, we should also like to communicate with you to confirm your appointments, send holiday greetings and newsletters about our practice. We will not sell your information or use it for any marketing purposes. If you have any questions, please ask and we will be happy to explain our policies.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your identifiable health information (PHI). In conducting our business, we must create records regarding you and the treatment services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

We may use and disclose your individually identifiable health information (PHI) in the following ways:

1. **Treatment.** The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may ask you to have an x-ray, and we will use the results to help or disclose your PHI in order to treat you or assist others in your treatment, such as a dental specialist. Additionally, we may disclose your PHI in order to treat you or to assist others in your treatment, such as a dental specialist. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer or dental plan to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your responsible for such costs, such as a family member. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers to assist in their billing and collection efforts.

3. **Appointments and reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment. For example, we may send appointment reminders and recall cards to remind you of an updoming office visit by mail, phone, or email.

4. **Non-medical communications.** Our practice may use your PHI to contact you for non-medical reasons. For example, we may send you a thank you card, newsletter or other communication via mail.

5. **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. **Open Areas.** There are open areas within our office where conversations with you regarding your care may be overheard by others. Every attempt will be made to minimize the exposure of your PHI, and if requested we will locate a private area in our office for our conversations with you.

7. **Release of information to family and friends.** Our practice may release your PHI to a friend or family member who is involved in your care or who assists in taking care of you. For example, parents or guardians may ask a grandparent to take their child to our office for treatment. In that case, the grandparent may have access to that child's medical information.

Signature _____ Date _____