



CHILDREN'S FORM



Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ Birthdate _____

Name of Minor Child _____ Sex M F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone(_____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (_____) _____

Person financially responsible _____ Home Phone (_____) _____ Work Phone (_____) _____

Drivers License _____

Whom may we thank for referring you _____

INSURANCE

Father's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (_____) _____ Work Phone (_____) _____ <small style="margin-left: 50px;">(if different from above)</small> <small style="margin-left: 100px;">(if different from above)</small> E-mail _____ Employer _____ Occupation _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (_____) _____ Address _____ Group # _____ Policy # _____	Mother's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (_____) _____ Work Phone (_____) _____ <small style="margin-left: 50px;">(if different from above)</small> <small style="margin-left: 100px;">(if different from above)</small> E-mail _____ Employer _____ Occupation _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (_____) _____ Address _____ Group # _____ Policy # _____
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DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form?	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head?	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day?	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences?	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?			<input type="checkbox"/>	<input type="checkbox"/>	

Signature of Parent/Guardian _____

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____

DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

		YES	NO			YES	NO
1. ARE YOU IN GOOD HEALTH.....	<input type="checkbox"/>		<input type="checkbox"/>	9. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION.....	<input type="checkbox"/>		<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	<input type="checkbox"/>		<input type="checkbox"/>	10. HAVE YOU HAD A RECENT WEIGHT LOSS.....	<input type="checkbox"/>		<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____				11. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	<input type="checkbox"/>		<input type="checkbox"/>
4. ARE YOU UNDER THE CARE OF A PHYSICIAN ...	<input type="checkbox"/>		<input type="checkbox"/>	12. DO YOU USE TOBACCO	<input type="checkbox"/>		<input type="checkbox"/>
ADDRESS _____				13. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	<input type="checkbox"/>		<input type="checkbox"/>
PHONE NUMBER _____				14. ARE YOU WEARING CONTACT LENSES	<input type="checkbox"/>		<input type="checkbox"/>
5. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	<input type="checkbox"/>		<input type="checkbox"/>	15. DO YOU HAVE A PERSISTENT COUGH OR THROAT ILLNESS (LASTING MORE THAN 3 WEEKS)	<input type="checkbox"/>		<input type="checkbox"/>
IF YES PLEASE EXPLAIN _____				16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT. _____			
6. HAVE YOU HAD ANY ABNORMAL BLEEDING	<input type="checkbox"/>		<input type="checkbox"/>				
7. DO YOU BRUISE EASILY	<input type="checkbox"/>		<input type="checkbox"/>				
8. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINES SUCH AS ASPIRIN.....	<input type="checkbox"/>		<input type="checkbox"/>				
IF YES, WHAT MEDICINE(S) _____							

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT

ARE YOU NURSING

ARE YOU TAKING BIRTH CONTROL PILLS.....

		YES	NO			YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:							
A. LOCAL ANESTHETICS LIKE NOVOCAIN	<input type="checkbox"/>		<input type="checkbox"/>	15. STOMACH ULCERS	<input type="checkbox"/>		<input type="checkbox"/>
LIST DRUGS AND REACTIONS _____				16. THYROID PROBLEMS	<input type="checkbox"/>		<input type="checkbox"/>
B. PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>		<input type="checkbox"/>	17. SINUS PROBLEMS	<input type="checkbox"/>		<input type="checkbox"/>
LIST DRUGS AND REACTIONS _____				18. LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>		<input type="checkbox"/>
C. METALS SUCH AS MERCURY OR NICKEL.....	<input type="checkbox"/>		<input type="checkbox"/>	19. ASTHMA OR HAY FEVER.....	<input type="checkbox"/>		<input type="checkbox"/>
LIST THE METALS _____				20. HIVES OR SKIN RASH	<input type="checkbox"/>		<input type="checkbox"/>
D. LATEX OR RUBBER.....	<input type="checkbox"/>		<input type="checkbox"/>	21. AIDS OR HIV INFECTION	<input type="checkbox"/>		<input type="checkbox"/>
LIST WHAT REACTION _____				22. ALLERGIES	<input type="checkbox"/>		<input type="checkbox"/>
E. PAIN MEDICATIONS SUCH AS CODEINE OR VICODIN	<input type="checkbox"/>		<input type="checkbox"/>	23. ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>		<input type="checkbox"/>
LIST DRUGS AND REACTIONS _____				24. KIDNEY TROUBLE	<input type="checkbox"/>		<input type="checkbox"/>
F. SULFA DRUGS	<input type="checkbox"/>		<input type="checkbox"/>	25. TUBERCULOSIS	<input type="checkbox"/>		<input type="checkbox"/>
G. BARBITURATES, SEDATIVES, OR SLEEPING PILLS	<input type="checkbox"/>		<input type="checkbox"/>	26. PERSISTENT COUGH	<input type="checkbox"/>		<input type="checkbox"/>
H. IODINE.....	<input type="checkbox"/>		<input type="checkbox"/>	27. COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>		<input type="checkbox"/>
OTHER NOT MENTIONED ABOVE, PLEASE LIST HERE _____				28. CHEMOTHERAPY (CANCER, LEUKEMIA)	<input type="checkbox"/>		<input type="checkbox"/>
				29. SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>		<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:							
1. HEART DEFECT OR HEART MURMUR.....	<input type="checkbox"/>		<input type="checkbox"/>	30. EPILEPSY OR SEIZURES	<input type="checkbox"/>		<input type="checkbox"/>
2. RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>		<input type="checkbox"/>	31. ANEMIA.....	<input type="checkbox"/>		<input type="checkbox"/>
3. HEART TROUBLE, HEART ATTACK, OR ANGINA ..	<input type="checkbox"/>		<input type="checkbox"/>	32. GLAUCOMA	<input type="checkbox"/>		<input type="checkbox"/>
4. CHEST PAIN.....	<input type="checkbox"/>		<input type="checkbox"/>	33. NERVOUSNESS.....	<input type="checkbox"/>		<input type="checkbox"/>
5. SHORTNESS OF BREATH.....	<input type="checkbox"/>		<input type="checkbox"/>	34. TONSILLITIS	<input type="checkbox"/>		<input type="checkbox"/>
6. PACEMAKER	<input type="checkbox"/>		<input type="checkbox"/>	35. TUMORS	<input type="checkbox"/>		<input type="checkbox"/>
7. HEART SURGERY.....	<input type="checkbox"/>		<input type="checkbox"/>	36. MENTAL HEALTH CARE	<input type="checkbox"/>		<input type="checkbox"/>
8. HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>		<input type="checkbox"/>	37. BACK PROBLEMS.....	<input type="checkbox"/>		<input type="checkbox"/>
9. CONGENITAL HEART PROBLEM	<input type="checkbox"/>		<input type="checkbox"/>	38. CHEMICAL DEPENDENCY	<input type="checkbox"/>		<input type="checkbox"/>
10. HEPATITIS, JAUNDICE OR LIVER DISEASE.....	<input type="checkbox"/>		<input type="checkbox"/>	39. CORTISONE TREATMENT	<input type="checkbox"/>		<input type="checkbox"/>
11. STROKE	<input type="checkbox"/>		<input type="checkbox"/>	40. COLD SORES/FEVER BLISTERS	<input type="checkbox"/>		<input type="checkbox"/>
12. MITRAL VALVE PROLAPSE	<input type="checkbox"/>		<input type="checkbox"/>	41. HYPOGLYCEMIA	<input type="checkbox"/>		<input type="checkbox"/>
13. DIABETES.....	<input type="checkbox"/>		<input type="checkbox"/>	42. EATING DISORDERS	<input type="checkbox"/>		<input type="checkbox"/>
14. JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>		<input type="checkbox"/>	43. FAINTING OR DIZZY SPELLS	<input type="checkbox"/>		<input type="checkbox"/>
				44. SCARLET FEVER	<input type="checkbox"/>		<input type="checkbox"/>

FORM 191021 R/05/07 ITEM 8101

PATIENT NUMBER _____

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE ..	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE)	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____

PATIENT NUMBER _____

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?

Why a privacy policy now?

Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

Protecting Your Confidential Health Information is Important to Us

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Our Privacy Officer is:
Betsy Witt

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Please appoint your health spokesperson.

Name _____

Date _____

Patient Acknowledgment

Patient Name(s) _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

Patient Signature _____

Date _____

VALLEYWIDE DENTAL, INC.

ROBERT HAZE D.D.S.
1021 West Ave M-14
Palmdale, Ca 93551
(661) 267-4000

Our Financial Policy

<u>Policy:</u>	Payment is required at the time of service. If you need to make financial arrangements please inform us in advance (prior to your next appointment)
<u>Methods of payment:</u>	We accept credit cards (Visa, MasterCard, Discover and American Express), ATM's, Cash, Personal Check (Electronic Fund Transfer) and CareCredit.
<u>Insurance payment:</u>	As a courtesy to you our office will submit a dental claim to your dental insurance company at no additional fee to you. However, you are responsible for the cost of all services regardless of the coverage your particular policy may or may not offer. The portion of your service not covered by insurance will be determined by an estimate and/or a pre-authorization. This portion known as the "co-payment" is expected to be paid at the time of service. Adjustments are sometimes needed when the final insurance reimbursement has been received by our office. Any balance you may owe as the result of an adjustment would be due and payable within 60 days from the date of service.
<u>Advance payment discount:</u>	A five percent (5%) discount is applied when the entire (Patient's share) treatment plan is paid in full.
<u>Senior discount:</u>	Our Senior discount is 7% if the entire treatment plan is paid in advance.
<u>Our Treatment Coordinators:</u>	Will inform you of the ESTIMATED cost of your treatment. Please note that Payment is required at the time service is rendered.
<u>Cancellation Policy:</u>	We require a 24-hour notice prior to any cancellations and/or rescheduling. The charge will be \$50.00 for every hour reserved for that appointment.

**** Please sign in acknowledgement of policy.**

(signature)

(date)

*Welcome to our office and thank
you for choosing us.*

Revised 4/22/08
Approved by