LAKE AVENUE DENTAL

Welcome to our Practice

Name: (Last)_____(First)_____ (MI)_____ **Preferred Name**:_____

Title:_____ **Gender:** ☐ Male ☐ Female **Family Status:** Married Single **Child** **Other**

Address: _____ **City:** _____**State:** _____ **ZIP:**_____

SSN: _____**Date of Birth:** _____ **E-mail Address:**_____

Cell Phone:_____ **Home Phone:** _____ **Cell Phone:** _____

Employment Information

Employer Name:_____ **Phone:** _____

Address:_____
_____

Whom may we thank for referring you to our practice?_____

In an emergency, who should be notified? (Name, Phone number, Relationship**)**
_____

Insurance Information

Subscriber Name: _____ **Relationship to Patient:** _____

Subscriber DOB: _____ **Subscriber SSN/ID:** _____

Subscriber Employer: _____ **Insurance Company Name:** _____

Insurance Company Address: _____

Insurance Company Phone: _____ **Group Number:** _____

Any Additional Insurance Information: _____
_____

By Checking this Box,

- I authorize my insurance company to pay the dentist all insurance benefits rendered
- I authorize the dentist to release all information necessary to secure the payment of benefits
- I understand that I am financially responsible for all charges whether or not paid by insurance

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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.

A broken appointment fee of **$75** will be charged to patient for all missed appointments and appointments cancelled with less than 48 hrs notice.

In consideration for the professional services rendered to me by this practice. I agree to pay the charges for the services at the time of treatment or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

By Checking this box, I understand the above information and agree to it's contents.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of

providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice and any other use required by law. I authorize the practice to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis. I authorize that photos/radiographs can be mailed/emailed to referring doctors/insurance companies. I authorize the use of anesthesia, and other medications (as needed) and I am fully aware that using these agents involve certain risks.

By checking this box, I understand the above information and agree with its contents.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.

Photograph Consent

I give my consent to Lake Avenue Dental to take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile and intraoral features, pre-, during, and post treatment for the purpose of internal office use in dental records or for use in treatment planning, education, publication in professional journals, and/or advertising. I understand that my identity will be blurred in most cases and that my personal information will be protected.

By checking this box, I understand the above information and agree with its contents

Acknowledgement of Notice of Privacy Policy

I have been advised of this office's notice of privacy practices and have been offered a copy:

Please Print Name: _____

Signature: _____

Date: _____