Patient Information

First name: _____ Middle initial: _____ Last name: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone #: ( ) _____ - _____ Email Address: _____

Patient Social Security Number _____ - _____ - _____ Patient Date of Birth _____/ _____/ _____

Emergency Contact Info: _____ Phone #: (_____) _____ - _____

Preferred method of contact: ☐ email ☐ text ☐ call

INSURANCE INFORMATION Do you have dental insurance? **YES NO**

	PRIMARY INSURANCE		**SECONDARY INSURANCE**
Subscriber Name		Subscriber Name	
Subscriber Social security #		Subscriber Social security #	
Subscriber Date of Birth		Subscriber Date of Birth	
Patient Relationship to Subscriber	SELF SPOUSE CHILD OTHER	Patient Relationship to Subscriber	SELF SPOUSE CHILD OTHER
Member/Subscriber #		Member/Subscriber #	
Insurance Company		Insurance Company	

PLEASE PRESENT INSURANCE CARD TO FRONT DESK

Preferred Pharmacy Name & Address

_____

_____

FINANCIAL RESPONSIBILITY

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept Visa, MasterCard, Discover and CareCredit. Any deductible or estimated co-payment amount will be due at the time of treatment.

Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

Insurance benefits are determined by either the state or your employer, not your dentist. **Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment.** We are happy to file your claim for you if you present your dental insurance card and all required subscriber information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

If payment for services already rendered has not been paid in full within 90 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

Patient or Guardian Signature: _____ Date: _____

COLLECTION FEES POLICY

I understand that if I have an unpaid balance or credit on my account past 60 days old, Peace Garden Dental will charge a reasonable fee for time and effort in calling and/or sending letters in an effort to collect payment. This will only be charged after 60 days of unpaid balances. Once your account balance has aged past 60 days with no payment activity and multiple opportunities to reconcile your account, your information will be forwarded to a collection agency of our choosing in order to collect these debts.

Patient or Guardian Signature: _____ Date: _____

LATE ARRIVAL POLICY

A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the office for their scheduled appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be given the option of either being seen that day as a walk – in, if the schedule permits, or rescheduled for a later date. This process will ensure patients who do arrive on time are seen in a timely manner.

Patient or Guardian Signature: _____ Date: _____

MISSED APPOINTMENTS POLICY

A “no show” is a patient who fails to appear for a scheduled appointment without providing a 48-hour cancellation notice. Further, a rescheduled appointment that is less than the 48-hour cancellation notice is still considered a cancellation and is treated as such. There is a $60 charge for all no-show visits. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

To assist the patient in keeping appointments, we will initiate a reminder via text, email or phone call before the patient’s scheduled appointment. During the reminder text, email or phone call, a patient is offered the opportunity to either confirm or reschedule the appointment. All reminder communications are documented in the patient’s electronic health record. The patient is responsible for canceling or rescheduling the appointment no less than 48 hours before the scheduled appointment.

If there are two no show appointments documented in your electronic health record, dismissal from the practice will be considered. In the event that you are dismissed from Peace Garden Dental, you will be notified by letter of this dismissal.

Patient or Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

HIPAA Requirements

The Practice:

- Is required by federal law to maintain the privacy of your (PHI) protected health information and to provide you with this privacy notice detailing the practice's legal duties and privacy practices with respect to your PHI.
- Under the privacy rule, the practice may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- Is required to abide by the terms of this privacy notice
- Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised privacy notice to you prior to implementation.
- Will not retaliate you for filing a complaint.

Effective Date: this notice is in effect as of 08/01/2023

Patient Acknowledgment:

By signing my name below, I acknowledge receipt of a copy of this notice and my understanding and my agreement to its terms.

Patient or Guardian Signature: _____ Date: _____

Personal Health Information and HIPAA Consent Form

Peace Garden Dental is authorized to release my personal health information to:

_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**

IF YOU WOULD LIKE A COPY OF OUR PRIVACY POLICIES, PLEASE REQUEST THEM AT THE FRONT DESK

TREATMENT POLICY

I, the undersigned patient, herby acknowledge and understand that dental treatment and procedures are complex and may vary in their outcomes. While the dental provider endeavors to provide the highest quality of care, there is no warranty, either expressed or implied, associated with the dental work I receive at this clinic. I am aware that the results of dental treatment can vary from person to person and no specific results can be guaranteed.

I understand that the success of dental treatment may depend on various factors, including but not limited to:

- My overall health and medical history
- My commitment to proper oral hygiene practice
- My compliance with post-treatment instructions
- The nature and complexity of the dental condition being treated
- The inherent limitations of dental procedures

I agree that I will not hold the dental clinic, dentist, or any staff members responsible for any unfavorable or unexpected results of dental treatment. I release the dental clinic and its personnel from any liability related to the outcomes of my dental treatment.

By signing below, I acknowledge that I have read and understood this dental warranty disclaimer, and I voluntarily consent to receive dental treatment at this clinic, fully understanding the lack of any warranty on the results of such treatment.

Patient or Guardian Signature: _____ Date: _____

INFORMED CONSENT FOR RADIOGRAPHS

Peace Garden Dental follows the guidelines of the American Dental Association and recommends that a full mouth series of radiographs be taken once every 3 to 5 years and bite wing radiographs once every year. Current radiographs will be necessary before any diagnosis can be finalized. I authorize the Dentist to prescribe radiographs following these guidelines.

Patient or Guardian Signature: _____ Date: _____