green valley DENTAL
Family Focused Dentistry

Written Financial Policy

Thank you for joining the Green Valley Dental Family! Our mission is to exceed the expectations of our community and patients, providing them with the proper education, caring nature and dental treatment everyone deserves. We understand an important part of this goal is making the financial aspect of one's optimal care as easy and manageable as possible. Therefore, we offer several payment options.

1.) Cash or Check
2.) Credit Cards
    -We accept most major credit cards
3.) Convenient Monthly Payment Plans with **Care Credit®**
    -No Interest for 12 months (application/qualification necessary)
    -No annual fees or pre-payment penalties
    -Allows you to pay more over time
4.) In-House Financing
    -A finance charge of 12% interest will be applied to accounts 90 days past due.

At Green Valley Dental we provide our patients with exceptional treatment in good faith that **full payment will be received at the completion of such treatment**. Should you decide to discontinue treatment prior to completion, your refund will be determined upon review of the case.

For patients with **dental insurance**, we are happy to work with your carrier to maximize your benefits. We will directly bill them for re-imbursement for your treatment and send you a convenient monthly statement explaining your coverage and remaining balance, if any.

- A 5% discount is given to all senior citizens without insurance paying with check or cash.
- A $25.00 charge will be applied for all returned checks.
- A $50.00 charge will be applied to a patient who misses or cancels more than 2 appointments in a calendar year without 24 hours notice.
- Only one discount per patient

If you have any questions, please **do not hesitate** to ask!! We are here to make your dental experience as comfortable and easy as possible.

_____ _____ _____

Patient, Parent, or Guardian Signature | Patient Name (Please Print) | Date

PATIENT REGISTRATION

green valley DENTAL
Family Focused Dentistry

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-Mail: _____ ☐ I would like to receive correspondences via e-mail

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to the Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to the Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

MEDICAL HISTORY

green valley DENTAL
Family Focused Dentistry

Patient Name: _____ Birth Date: _____

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you uses controlled substances? ◯ Yes ◯ No

Women - Are you:

Pregnant / Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other - Explain: _____

Do you have, or have you had, any of the following?

AIDS / HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis / Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells / Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach / Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attach / Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores / Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble / Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ DATE: _____

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 it 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.

Patient Acknowledgement

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: _____ /_____ /_____

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 offices, 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 concern or complaints in writing.

green valley DENTAL
Family Focused Dentistry

Financial Responsibility Information

1.) For patients with dental insurance, Green Valley Dental will always do our best to help you interpret and maximize your benefits. However, please understand that there are over 3000 different policies that we work with!
2.) We are happy to submit dental claims on your behalf as well as research your allowed maximums, deductibles, and eligibilities to the best of our ability. As a courtesy, we will directly bill them for re-imbursement towards your treatment along with sending you a convenient monthly statement explaining your coverage and remaining balance, if any.
3.) Please keep in mind that your insurance policy is a contract between you, your employer when applicable, and the insurance company.
4.) We ENCOURAGE our patients to familiarize themselves with their policy, as sometimes they can change when contracts renew, and often without clear communication.
5.) I understand that I am fully financially responsible for the treatment I accept and is completed by the team and dentists at Green Valley Dental.

Our main priority at Green Valley Dental is to be YOUR healthcare advocate! We take pride in treating all our patients with respect, honesty, and a clear commitment to keep your health as our main priority.

Unfortunately, there are many times where this doesn't coincide with, "What does my insurance cover?". Our purpose is to offer you recommendations and solutions to the problems we see and leave the decisions (YOUR DECISIONS) on how to proceed up to you.

Patient Name Date

green valley DENTAL
Family Focused Dentistry

Methods of Payment

1.) Cash or Check

- "Pay Today Courtesy Discounts" available. (ask our treatment coordinator for details)
- 5% discount is given to all senior citizens without dental insurance

2.) Credit Cards

-We accept most major credit cards
- Discounts do not apply when paying with a credit or debit card

3.) Convenient Monthly Payment Plans

-No Interest Options (application/qualification necessary)
-No annual fees or pre-payment penalties
-Allows you to pay more over time

4.) In-House Financing

-A finance charge of 12% interest will be applied to accounts 90 days past due.

- A $25.00 charge will be applied for all returned checks.
- A $35 charge will be applied for a canceled or failed appointment with less than 24 hours notice.
- Only one discount per patient.

At Green Valley Dental, we provide our patients with exceptional treatment in good faith that **full payment will be received at the time of service**. Should you decide to discontinue treatment prior to completion, your refund will be determined upon review of the case.

If you have any questions, please **do not hesitate** to ask!! We are here to make your dental experience as comfortable and easy as possible.

Patient Name Date

green valley DENTAL
Family Focused Dentistry

Investment in Your Health

Recommended Procedure(s)

1._____

2._____

3._____

4._____

Green Valley Dental's Fee

$_____

Negotiated Fee with Your Insurance

$_____

ESTIMATED Insurance Benefit and Coverage (%)

_____

ESTIMATED Investment by You

$_____

Calculations

-I give my full, informed consent for Green Valley Dental to perform the recommended procedures on me.

-I fully understand that the figures mentioned above are only ESTIMATES based on the information that was given to Green Valley Dental by my insurance company and this does not guarantee reimbursement towards my recommended/completed treatment.

-I fully understand that I am ultimately responsible for any costs associated with my treatment, even in the event my insurance company doesn't provide the expected estimated benefit or denies the claim.

_____

Patient Name Date

green valley DENTAL
Family Focused Dentistry

Reserved Appointments

An appointment time has been *reserved especially for you!*

We will always do our best to respect your schedule, and ask that you do the same for us and our other patients. This helps our office run smoothly and allows us to stay on time and avoid any unnecessary waiting on your behalf.

When making an appointment, please be sure that your other obligations allow you adequate time to arrive promptly for your dental visit. If you know that you are going to be **10 minutes late, please call** prior to your appointment time. If it becomes necessary to reschedule, we can do so at that time.

Although we know that unforeseen events and circumstances arise from time to time, it is important for patients to honor their appointments so that we can treat everyone in a timely manner and with exceptional quality care!

-If you are unable to make your scheduled appointment, we request a minimum **48-hour cancellation notice**.

-Any cancellations made within **24 hours** of the scheduled appointment or failure to show up for your appointment, will result in a **$35** charge.

-Should you need to reschedule or cancel a reserved appointment, we require you call the office and speak directly to one of our team members for assistance, or if after hours, by leaving a detailed voicemail.

Thank you for your cooperation, courtesy, and understanding!

Patient Name Date