Appointment Date: _____

Patient Information

Patient Name: _____ Preferred name: _____ ☐ Male ☐ Female
Last First

Birthdate: _____ Social Security #: _____

Phone (Home): _____ (Cell): _____

Preferred Contact E-Mail Address: _____

Address: _____
Street Unit or Apartment #

_____
City State Zip Code

Health Information

Date of your child's last dental visit: _____ Reason for this visit: _____

Has your child ever had any of the following? Please check those that apply:

- ☐ Allergy – Latex
- ☐ Allergy – Food
  _____
  _____
- ☐ Allergy – Drug
  _____
  _____
  Allergy – Seasonal
  _____
  _____
- ☐ Allergy – Other
  _____
- ☐ Anemia
- ☐ Apraxia
- ☐ Asperger Syndrome
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Eye Condition
  _____
- ☐ Head Injuries
- ☐ Heart Disease
  _____
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Sensory Issues
  _____
- ☐ Sinus Problems
- ☐ Seizures
- ☐ Other _____
  _____

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Is your child now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- List any medications your child is taking: _____
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my child's health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Pediatrician ☐ Advertising ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Parent or Guardian Information

FATHER: _____ ☐ **Married** ☐ **Single** ☐ **Other**

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address (if different from child): _____

Employer Name: _____ Occupation: _____

MOTHER: _____ ☐ **Married** ☐ **Single** ☐ **Other**

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address (if different from child): _____

Employer Name: _____ Occupation: _____

Primary Insurance Information

Policy Holder's Name: _____ Relationship to Patient _____

Social Security #: _____ Birth Date _____

Insurance Carrier Name: _____

Contract ID #: _____ Group #_____

Policy Holder's Employer:_____

Policy Holder's Address (if different from child): _____

Secondary Insurance Information

Policy Holder's Name: _____ Relationship to Patient _____

Social Security #: _____ Birth Date _____

Insurance Carrier Name: _____

Contract ID #: _____ Group # _____

Policy Holder's Employer:_____

Policy Holder's Address (if different from child): _____

Consent for Services and Guarantor Agreement

As a condition of your child's treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 15 days, unless previously written financial arrangements are satisfied.

In consideration of the professional services rendered by Doctor Jarmoszuk on my child, I agree to pay Doctor Jarmoszuk, or her assignee, the reasonable value of those services at the time they are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of the services rendered shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 fees, including reasonable attorneys' fees, associated with the collection of any amounts past due related to the services rendered on my child.

I grant my permission to you or your assignee, to contact me or leave messages for me by any of the above means (address, home phone, work phone, cell phone, e-mail, or text) to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of parent, guardian and/or responsible party

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** patient's family name Guardian/Legal Representative signature

_____

Relationship of Guardian/Legal Representative

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR CHILD'S HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY CHILD'S APPOINTMENTS, TREATMENT & BILLING INFORMATION AND OFFICE NOTIFICATIONS (UNEXPECTED OFFICE CLOSURES, SPECIAL OFFICE PROMOTIONS)** VIA:

☐ Cell Phone Confirmation/Text Message_____

☐ Home Phone Confirmation ☐ Email Confirmation_____

☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY CHILD'S HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation/Text Message_____

☐ Home Phone Confirmation ☐ Email Confirmation_____

☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____

Signature of Privacy Officer

FINANCIAL and APPOINTMENT POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (VISA, MasterCard, Discover, American Express and Care Credit Payment Plan).

2. If you have insurance we will gladly process your claim. **We request that you pay your <u>ESTIMATED</u> portion when services are rendered. Any amount not covered by your insurance or any difference in the estimated portion is the parent's or guardian's responsibility.** Our office will file your insurance a maximum of **two times** per appointment. **The office will accept assignment for only the primary insurance coverage** and any secondary insurance payment will be sent directly to the patient. We will gladly provide you with a receipt for secondary insurance filling.

If the claim is not paid by your insurance carrier within 45 days, you will be responsible for the full balance and any further insurance appeal is your responsibility. We will be happy to provide you with a claim form so that you can follow up on your child's insurance claims personally.

3. You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If we are unable to verify your insurance prior to the time of your child's appointment, you will be responsible for payment of all fees.

4. You will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule**. Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of the dentist.

5. **After 30 days all unpaid balances become past due regardless of whether insurance is pending**. A service charge of 1½ percent per month (18% per annum) - $3.00 minimum - will be assessed on any unpaid balance. In the event we have to initiate collection proceedings to collect a past due account, the parent/responsible party agrees to be responsible for the costs of collections including reasonable attorney fees.

6. There will be a $30.00 service charge for all returned checks.

7. **The parent (legal guardian) accompanying the child is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.**

We reserve time in our schedule especially for your child and in consideration of others, **WE REQUEST AT LEAST 48 HOURS' NOTICE PRIOR TO CANCELLATION OF APPOINTMENTS.** We do understand that there are circumstances that may prevent you from keeping your child's appointment. However, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 48 hours' notice does not allow us enough time to schedule another patient in need of treatment.

WE RESERVE THE RIGHT TO CHARGE A $50.00 FEE FOR ANY MISSED APPOINTMENT OR UNDER 48/HOUR NOTICE. Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment.

Patients may have their appointment rescheduled if they are more than 15 minutes late for their appointment time which is out of respect for the on-time patient that follows. A $50.00 fee for the missed appointment would apply.

Appointments cancelled with less than 48 hours' notice on a school holiday or an after school time will NOT be rescheduled on another school holiday or after school appointment time, as they are the most popular appointments.

AUTHORIZATION

1) I authorize Dr. Sonja A. Jarmoszuk and staff to release any information concerning my child to our insurance company
2) I have read & accept the above Financial Policy understand it and agree to the terms set forth regarding payment.

Signature of Parent or Responsible Party	Printed Name	Date