Patient Information

**Patient’s Name:**

Gender: Male or Female

DOB

Social Security Number

Address

City, State, Zip

Phone #

If mobile number, would you prefer call or text reminders? Call Text

Emergency Contact:

Name Relationship

Phone Number

Please list any other family members who are patients

Referred by (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information

*\*Please bring a copy of your insurance card to your appointment\**

Subscriber’s Name

Subscriber’s Relationship to Patient

Subscriber’s Social Security Number

Subscriber’s DOB

Subscriber’s Place of Employment

Name of Insurance Plan

Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address

Insurance Phone Number

Group Number

Dental Office Policy

**Payments/Unpaid Insurance Claims** We accept cash, check, Visa, Mastercard, and Discover. Payment of your “estimated portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance to provide an “estimate” of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits, nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their benefits quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office actual fees. This could result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment is due by the due date printed on the statement. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you after all insurance claims are processed on the account. If patient portion is not remit within 90 days of insurance payment, your account is considered delinquent until the past due balance is paid. A delinquent account is eligible to be submitted to small claims court, if no contact is made with the guarantor of the account.

All dental services rendered, whether covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance 60 days to remit payment. If there is still no payment after this time, to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

**Broken Appointments** Our commitment to providing timely dental care and respecting everyone’s time is dependent on patient attendance. If a patient is scheduled for an appointment and is unable to make it at the scheduled time, please call the office as soon as possible. We understand that unforeseen circumstances happen that prevent you from ever missing an appointment. If three (3) scheduled appointments are broken and no notice was given your account will be billed a $20 fee for not attending appointments. Additionally, due to the popularity of Thursday EVENING appointments, if one (1) appointment is missed or cancelled without a 24-hour notice, a $20 fee will be charged to the account. Missing appointments and not noticing ahead of time limits other patients from being able to fill those appointment openings. If possible, please give 24-hour notice if you are unable to attend an appointment.

Signature and Date

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.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **January 1, 2023** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, of for additional copies of this Notice, please contact us by using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:**We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:**We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:**We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:**In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:**We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:**We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your acre, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:**We will not use your health information for marketing communications without your written authorization.

**Required by Law:**We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:**We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:**We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:**We may use or disclose your health information to provide you with an appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS**

**Access:**You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format rather than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \_$1.00\_\_ for each page, \_$10.00\_\_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:**You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a twelve-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:**You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:**You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:**You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:**If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S Department of Health and Human Services.

**AUTHORIZATION TO RELEASE PERSONAL HEALTH AND/OR ACCOUNT INFORMATION TO FAMILY AND FRIENDS**

I authorize **Fay Family Dental Care LLC** to release health and/or account information identifying me under the following terms and conditions.

All detailed personal information (such as: full treatment, health and account)

**May we leave you a deatiled message on the number you provided?**

YES

NO

Please provide first and last name and relationship and phone number of any person that we may release information to.

I understand that I may revoke this authorization in writing at any time, except for the information that has already been disclosed by Fay Family Dental Care in reliance on this authorization, by sending a written revocation to Fay Family Dental Care LLC 135 N. Sandusky Ave. Upper Sandusky, OH 43351.I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.

Signature and Date

### CONSENT TO TREAT MINOR CHILDREN

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby consent to any dental care and the administration of local anesthesia determined necessary for good oral health by Dr. Fay and staff. All treatment will be discussed in detail with the patient and the legal guard of the patient before starting any treatment. If anyone has questions or concerns we will discuss those matters before proceeding with any treatment.

If I call and schedule a prophy and exam for my minor and I am not present, I give Dr. Fay and the staff consent to proceed with the cleaning and exam, but any further treatment will be communicated with me prior to beginning.

Signature of Parent or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_