Consent of Services

As a condition of your 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 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services 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 reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work 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 patient, parent or guardian

_____Date_____
Relationship to Patient

_____
Signature of guarantor of payment/responsible party

8302 OLD YORK ROAD, SUITE B-10 ELKINS PARK,
PENNSYLVANIA 19027
TELEPHONE (215)277-1311 FAX (215) 690-4309
www.meadowfamilydental.com

FINANCIAL AGREEMENT FOR PROFESSIONAL SERVICES RENDERED

Name of patient _____

Name of responsible party if different than patient _____

Home Address _____

_____

_____

Telephone Number _____

Total amount owed as of today _____

Agreed payment plan _____ monthly installments of $_____each

and a final payment of $_____

1. The patient and responsible party named above ("You") acknowledge that you owe the total amount shown above to Meadow Family Dental Care, LLC., that this amount is for services rendered by Meadow Family Dental Care, LLC., and that this amount has not previously been paid and is now overdue, and that there are no defenses, counterclaims or set-offs to this debt.
2. You agree that you will pay the total amount owed today according to the agreed payment shown above, that is, in _____consecutive monthly installments of $_____ each plus a final payment of $_____. You also agree that you will make each payment by the_____ day of each month, starting with_____, and that your last payment will be made by _____.
3. You understand that, as long as you make the payments shown in this Agreement, no interest will be added to these amounts, however, IF YOU FAIL TO MAKE ANY OF THESE PAYMENTS BY THE AGREED DATES, you will be in default of this Agreement and the agreed payment plan will no longer apply. Instead, you will owe the total amount shown above, minus any amounts you have paid, plus a default interest rate equal to 1.5% per month (18% per annum), plus all costs of collection and surcharge of 15% of the total amount owed for our attorney's fee.
4. To avoid any further delay in payment, you have also been asked and have agreed to submit post-dated checks to this office in the amount of the agreed payments. You promise

that, if, on the date of any of these post-dated checks, you do not have sufficient funds in your checking account to cover the payment promised on that date, you will notify this office immediately, so that we can avoid depositing a check which will not clear your account. Unless we hear otherwise from you, we will assume that there are sufficient funds in your checking account on the date of each of the post-dated checks to pay the amount promised on that date.

5. To avoid any further delay in payment, you have also been asked and have agreed to submit your MASTERCARD or VISA account number and expiration date to this office to charge your credit card account for the amount of each of the agreed payments on the dates indicated above, or, should you fail to make an agreed payment, for the total amount owed to this office. By signing below, you authorize this office to keep your signature on file and to charge your MASTERCARD or VISA account for each of the payments described above.

I, as the person financially responsible for the debt referenced above, certify that I Have read this Agreement, that I understand what is written in this Agreement, and that I agree to everything that is written in this agreement.

_____ _____

Patient or responsible Party's Signature Date

_____

Print name here

_____ _____

Bank Name Checking Account Number

_____ _____

MASTERCARD/VISA Account Number Expiration date

THIS AGREEMENT AND ANY FUTURE COMMUNICATIONS FROM THIS OFFICE ARE AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE. If you do not dispute the validity of this debt or any portion of it within 30 days after receipt of this agreement, we will assume it is valid. If you dispute the validity of this debt or any portion of it in writing within 30 days, we will mail verification of this debt to you. At your written request, within 30 days, we will provide you with the name and address of the original creditor, if different from current creditor.

HEALTH HISTORY QUETIONARY

Your health history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment. This Health History Questionnaire will become a part of your dental treatment record and is considered "Confidential."

Date _____

Last Name _____ First Name_____
Address_____
City_____ State _____
Zip_____

Date of last DENTAL examination _____/_____/_____

Reason for today's visit: (circle)

Examination/Cleaning Pain/Swelling Broken Tooth/Filling

Have you previously been treated for this problem or concern? ☐ Yes ☐ No

How long has this been a problem or concern?
_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:
_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:
_____

Health History

Are you currently under the care of a physician? ☐ Yes ☐ No

Reason for last visit?
_____

Date of last physical examination _____/_____/_____

Physician's Name _____ Phone (_____) _____

Address

_____

City _____ State _____ Zip _____

Past Medical History

1. Have you ever had a serious illness, operation, or been hospitalized? If so, please explain:

_____

2. Has there been any change in your health in the last two (2) years? ☐ Yes ☐ No

If yes, please explain

_____

3. Have you ever had an allergic reaction? To: (circle)

Medication Food Latex Products

Other:

_____

Have you ever had any of the following? Please check those that apply:

AIDS	Allergies	Anemia	Arthritis	Artificial Joints	Asthma
Blood Disease	Cancer	Diabetes	Dizziness	Epilepsy	Excessive Bleeding
Fainting	Glaucoma	Growths	Hay Fever	Head Injuries	Heart Disease Heart
Murmur	Hepatitis	High Blood Pressure		Jaundice	Kidney Disease
Liver Disease	Mental Disorders	Nervous Disorders		Pacemaker	Radiation Treatment
Respiratory Problems		Rheumatic Fever		Rheumatism	Sinus Problems
Stomach Problems		Stroke	Tuberculosis	Tumors	Ulcers
Venereal Disease	Codeine Allergy	Penicillin Allergy		Acid Reflux	

4. Do you now or have you ever used tobacco? ☐ Yes ☐ No

If you currently use tobacco, are you interested in quitting? ☐ Yes ☐ No

5. How many alcoholic drinks do you consume: a day? _____ a week? _____ a month? _____

6. For women:

   i) Are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No

   ii) Are you taking birth control pills? (circle) ☐ Yes ☐ No

Current Medications: **Prescribed and Over-the-Counter**

Name of Medication, Dose Frequency

1._____

2._____

3._____

4._____

5._____

*If you need more space please use the back of this form

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 health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of Patient or Guardian Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[*45 CFR 164.520*]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

- Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
- When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

Thank you for scheduling an appointment with Meadow Family Dental Care, LLC.

Please complete the enclosed new patient history and bring it with you at your first appointment.

If you have dental insurance, please also bring a dental insurance form with all of your information completed and signatures where required.

Thanks you and we look forward to meeting you

Sincerely,

_____ _____

Signature of Patient or Guardian Date

8302 OLD YORK ROAD, SUITE B-10 ELKINS PARK,
PENNSYLVANIA 19027
TELEPHONE (215)277-1311 FAX (215) 690-4309
www.meadowfamilydental.com

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ cell #: _____

Preferred appointment times:

☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

☐M ☐T ☐W ☐T ☐F ☐S

Address:

_____
Street Apartment #

_____
City State Zip Code

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

_____

Name of person or office referring you to our practice:

_____

_____

_____

_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:

_____

☐ Male ☐ Female

☐ Married ☐ Single ☐ Child ☐ Other

_____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ Ext: _____

Best time to call: _____

Address:

_____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

_____

Phone: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Date of Birth: _____

ID #: _____

Group #: _____

Insured's Address:

_____
Street City State Zip Code

Insured's Employer Name:

_____

Address:

_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:

_____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Date of Birth: _____

ID #: _____

Group #: _____

Insured's Address:

_____
Street City State Zip Code

Insured's Employer Name:

_____

Address:

_____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:

_____

_____