Sandalwood Family Dentistry Office Policies

We greatly appreciate that you have selected our office to care for your dentals needs. We value our patients and strive to provide the highest quality, most cost-effective dentistry.

In order to accomplish this goal we have established several office policies that we would like you to understand before we proceed.

- **Parent Information:** Parents are welcome to accompany their child into the treatment room for examinations. This gives you the opportunity to see our staff in action and allows Dr. Menning /Dr. Strepka to discuss your child's dental needs with you. For treatment appointments, *you must remain in the waiting room* unless the doctor requests your presence in the back. Exceptions to this policy will only be made for special- needs children.

- **Appointment Policy:** As a courtesy, we will call you by phone one week prior to your appointment to confirm your visit. If we do not hear back from you to confirm by 48 hours prior to your appointment, we will be forced to cancel the appointment. No-shows are not acceptable. Failure to make your appointment inconveniences other patients who would like to have their needs met. There is a $50 fee for any broken appointments. A broken appointment is a no-show or a failure to reschedule without 48-hour notice.

- **Timeliness is required:** In order to see our patients in a timely manner, it is important that you are on time as well. If you are more than 15 minutes late, we may need to reschedule or modify your appointment.

- **Insurance:** Treatment recommendations are based upon your health and not on your insurance or lack thereof. If you have insurance, it is your responsibility to understand your plan benefits. *Remember, your insurance company does not care about your health or well- being. We do.* We will provide you an estimate of benefits; however, you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what they will or will not cover. We make every attempt to utilize your benefits, but ultimately you are responsible if your insurance fails to pay for treatment. We will not file secondary dental insurance. We will submit a claim a maximum of two times. If insurance still fails to pay towards your treatment, you will be responsible for the balance.

- **We run a zero-balance office**, we expect payment in full prior to or at the time treatment is provided. We have several financial options available for all patients. In order to book an appointment for treatment we require 50% of the total patient out of pocket expense as a deposit for the appointment.

- **Upsets:** It is our policy to aim for complete satisfaction for all our patients. However, in the event of a miscommunication, we will do everything in our power to make things right by you. We hope that you would bring it to our attention in a cordial manner, so that we may give the matter our full attention and come to a resolution. Our team will treat you in a professional manner and if we fail to do so, please contact Mindy, our office manager.

- **Emergencies:** It is our goal to eliminate all of the potential dental emergencies you may have by providing dental care before it becomes a problem. in the rare instance that you have an emergency, we want you to be assured that we will take care of you. if you have swelling, bleeding, severe pain or a restoration that has broken in a visible area, these are considered emergencies. we do set aside time each day to see emergencies. Many common dental problems can be addressed on our website, www.sandalwooddental.com

I have read and accept the office policies set forth here.

Patient/Guardian Signature_____ Date_____

Sandalwood Family Dentistry

Financial Policy

Thank you for choosing our office for your dental needs. We are committed to providing you excellent care, and payment of your bill is part of successful treatment. Please read and sign the following:

Financial Agreement

In order to provide our patients with the most value, we have to run an efficient office. A huge part of that is minimizing cancellations and no-shows. **As such, payment of 50% of the expected patient portion is required to book an appointment for treatment.** The second half of the patient portion is due the day treatment is performed. In the event that your appointment is cancelled for any reason, we will keep up to $150 of your deposit based on your treatment plan. As this time is reserved for you specifically, insufficient notice affects our small business significantly. In the even payment is made via check and there are insufficient funds to cover the amount you will be charged a $40 returned check fee, in addition to the check amount.

Insurance Filing

You are ultimately responsible for payment in full of your account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. Ultimately, the plan that your employer has chosen to enroll you in will dictate whether or not your insurance pays towards your treatment. Your insurance company does not have your health care needs in mind. **In the event that your insurance company does not pay as much as expected, the remaining balance is due and payable by you, the patient.**

Assignment of Insurance Benefits

I/we hereby assign directly to Sandalwood Family Dentistry, dental insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

_____

Responsible Party Signature

Delinquent Accounts

All delinquent accounts (60 days or older) are subject to reasonable service charges and/or legal interest rates.

Collection Proceedings

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection cost (18%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service.

Failed Appointments

In order to better serve the needs of all our patients, missed appointments are subject to a $50 charge, unless we are notified at least 48 hours in advance. Please remember, once an appointment is made, that time is reserved specifically for you. If your appointment is set for Monday, we require notice of cancellation by 12pm Friday to avoid a fee.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

_____

Responsible Party Signature

QUESTIONS OR COMPLAINTS

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

Sandalwood Family Dentistry
11510 Barker Cypress Rd. #300
Phone: 281-758-1555

Matthew Strepka DDS
Email:sandalwooddental@hotmail.com
Fax: 832-653-6804

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Patient/Guardian Signature_____ Date_____

products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please check this box.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

☐ for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
☐ to avert a serious an imminent threat to health or safety;
☐ for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
☐ for research;
☐ in response to court and administrative orders and other lawful process;
☐ to law enforcement officials with regard to crime victims and criminal activities;
☐ to coroners, medical examiners, funeral directors and organ procurement organizations;
☐ to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
☐ as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;
2) Mental Health;
3) Genetic Tests (in accordance with GINA 2009);
4) Alcohol and drug abuse;
5) Sexually transmitted diseases and reproductive health information; and
6) Child or adult abuse or neglect, including sexual assault.

PATIENT RIGHTS

1) You have a right to see and get a copy of your health records.
2) You have a right to amend your health information.
3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by checking this box. ☐
6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
7) You have a right to restrict who receives your information.
8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
9) If you believe your rights are being denied or your health information is not being protected, you can:
a. File a complaint with your provider or health insurer
b. File a complaint with the U.S. Government
10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs you may do so by checking this box. ☐

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 law to protect the privacy of your protected health information.We are also required to send you this notice about our privacy practices, our legal duties and your right concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. **The notice takes effect on the date January 14, 2026** and will remain in effect unless we replace it. We reserve the right at any time to chage 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 any changes in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the changes in the practice.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention;
- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Phone: _____-_____-_____ Email: _____

Social Security: _____-_____-_____

SECTION B: *TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.*

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE of PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, and of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. We will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice by contacting:

Sandalwood Family Dentistry	Phone: 281-758-1555
11510 Barker Cypress Suite 300	Fax: 832-653-6804
Cypress, TX 77433	Email: sandalwooddental@hotmail.com

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the location listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: _____ Date: _____/_____/_____

If a personal representative on behalf of the patient signs this consent, complete the following:

Patient Representative Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT:

I have revoked my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature: _____ Date: _____/_____/_____

Women:

Are you pregnant? Yes _____ No _____ How many weeks? _____

Are you planning on becoming pregnant? Yes _____ No _____

Are you nursing? Yes _____ No _____

Are you taking birth control? Yes _____ No _____

Please list ALL medications and dosage you are currently taking:

- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____

Please review the following conditions and check all that apply:

☐ Cold Sores
☐ Oral Ulcers
☐ Acid Reflux / GERD
☐ Anxiety
☐ Depression
☐ Headaches
☐ Clenching / Grinding
☐ Diabetes
☐ Epilepsy
☐ Hyper/Hypothyroid
☐ Asthma
☐ Previous Heart Attack (When? _____)
☐ Heart Disease
☐ Heart Murmur
☐ Other heart condition
☐ High Blood Pressure
☐ Stroke
☐ Anemia
☐ Hepatitis (Type: _____)
☐ Rheumatic Fever
☐ HIV / AIDS (Including undetectable)
☐ Kidney Disease
☐ Liver Disease
☐ Glaucoma
☐ Enlarged Lymph Nodes
☐ Abnormal Bleeding
☐ Sinus Trouble
☐ Respiratory Illness

Have you been diagnosed with diabetes? Yes _____ No _____

Type 1 or Type 2 (circle one)

Do you use insulin? Yes _____ No _____

Do you have osteoporosis? Yes _____ No _____

Which medications (oral or IV) have you taken? _____

Have you ever been diagnosed with cancer? Yes _____ No _____

If yes, please explain: _____

Have you had any chemo or radiation? Yes _____ No _____

Have you had any joint replacements? Yes _____ No _____

If yes, please list type and date: _____

Do you have special needs (Autism, Down's Syndrome, etc.)? _____

I affirm that the information given is correct to the best of my knowledge and that it is my responsibility to inform Sandalwood Dental of any changes in my medical status. I understand that I could put my health at risk by failing to disclose my full health history.

Patient/Guardian Signature: _____ Date: _____

Health History

All information provided is strictly confidential.

Name of Medical Doctor: _____ Office Name: _____

Office Phone Number: _____

Specialist's Name: _____ Office Name: _____

Office Phone Number: _____

For new patients, what is your goal for today's visit: _____

When was your last dental check-up and cleaning? _____

Please check all that apply:

- ☐ Pain or discomfort with your teeth or gum
- ☐ Do your gums bleed when you brush/floss
- ☐ Do you grind your teeth during the night c
- ☐ Do you snore or have sleep apnea?
- ☐ Do you have discomfort in your jaw or he
- ☐ Do you have sensitive teeth?
- ☐ Current or past use of CPAP?

Are you interested in:

- ☐ Invisalign
- ☐ Implants to replace missing teeth
- ☐ Whitening your teeth
- ☐ Sedation dentistry
- ☐ Veneers
- ☐ Oral appliances to treat snoring or sle

Have you been hospitalized in the past 5 years? Yes _____ No _____

If yes, please explain: _____

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

If yes, please explain: _____

Are you required to pre-medicate (antibiotics) prior to your dental appointment? Yes _____ No _____

Any unusual reactions to dental injections in the past? Yes _____ No _____

If yes, please explain: _____

Have you been diagnosed with abnormal/high blood pressure? Yes _____ No _____

Are you allergic or had an adverse reaction to:

- ☐ Local Anesthesia
- ☐ Codeine / Other Pain Reliever
- ☐ Latex
- ☐ Penicillin / Other Antibiotics
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Jewelry / Metal
- ☐ Other: _____

Do you smoke or use:

- ☐ Cigarettes
- ☐ Cigars
- ☐ Smokeless Tobacco
- ☐ THC
- ☐ Vape

If yes to any of the above, how often? _____

Any history of drug/substance abuse? Yes _____ No _____

If yes, please explain: _____

Sandalwood
Family & Cosmetic Dentistry

WELCOME TO SANDALWOOD DENTAL!

Dr. Matthew Strepka / Dr. Diane Banks 11510 Barker Cypress Rd. #300 Cypress, TX 77433 P: 281-758-1555 F: 832-653-6804

At Sandalwood Dental, our goal is to connect with our patients on a human level—to establish a relationship built around honesty, education, and competent treatment. We have been given the opportunity to positively impact the oral health of those in our community, and with this opportunity comes responsibility. Our job is to provide our patients with the information that they need to make the best decision regarding the prevention and treatment of oral disease. We are committed to expanding our knowledge base through continuing education in order to bring the latest in dental care and technology to the table. Above all we seek to be fair, to give our patients more than they expect, and to do what is right. Now that we have the opportunity to build this relationship with you, we would like to get to know you better. Please fill in the information below.

Patient Information

Today's Date: _____/_____/_____

Patient Name: _____ Preferred Name: _____
Date of birth: ____/____/____ Age: _____ Gender: _____ Social Security #: ____-___-____

Mailing Address: _____ Apt#:_____ City:_____ Zip:_____
Home Phone: ____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____
E-mail: _____
Would you like email/text confirmations? Yes ___ No ___

Emergency Contact Information

Name: _____
Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____
Relationship to patient: _____

Dental Insurance Information

Insurance Company Name: _____ Provider Phone: _____-_____-_____
Group Number: _____ ID Number: _____
Policy Holder: _____ Policy Holder Social Security: _____-____-_____
Date of birth: _____/_____/_____ Employer: _____
Relationship to patient: _____

Additional Information

Whom may we thank for referring you? _____
How did you hear about us? _____
Other family members seen at Sandalwood Dental? _____