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 potion 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 1pm 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

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 text or email you 2 weeks prior to your appointment. We will also notify you by phone one week prior to your appointment. If we do not hear back from you to confirm by 48 hours prior to your appointment, we will be forced to reschedule you. 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 a 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 of 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________________

Appointment Reminder: We may use or disclose your health information to provide you with 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 format other than photocopies. We will use the format your 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 the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. Your 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 $25.00 per patient file for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If your request and alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of the 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 purpose, 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 12-moth 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 disclose 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 aout your health information by alternative means or to alternative locations. (You much 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 laction you request.

Amendment: You have the right to request that we amend your health information. (You 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 website 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:

Matthew Strepka DDS
Sandalwood Family Dentistry
11510 Barker Cypress Rd. #300
Cypress, TX 77433

E-mail: sandalwooddental@hotmail.com
Phone: 281-758-1555
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 health information or in response to a request you made to amend or restrict the use or disclosure of 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 also may 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 in you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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 April 14. 2003, 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 applicable law permits such changes. 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 practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose 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, and are not limited to, quality assessment and improvement activated, 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, via a separate form we can provide or a letter in your own writing, to use your health information or to disclose it to anyone for any purpose. If your give us a special 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 special written authorization, we cannot use or disclose your health information for any reason except those described in the 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.

Person Involved in Care: We may use or disclose health information to notify or assist in the notification of (inclusion identifying or location) a family member, your personal representative r another person responsible for your care, 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 judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medial 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, 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 other.

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

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
11510 Barker Cypress Suite 300
Cypress, TX 77433

Phone: 281-758-1555
Fax: 832-653-6804
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: ____/____/____

Health History

What is your goal for today's visit? ________________________ Date of last dental visit? ____/____/____

How would you describe the condition of your teeth and gums? Good ☐ Fair ☐ Poor ☐
How often do you brush your teeth? Twice a day ☐ Once a day ☐ Once in awhile ☐
How often do you floss your teeth? Twice a day ☐ Once a day ☐ Once in awhile ☐

Are you currently experiencing any discomfort with your teeth or gums? Yes ☐ No ☐

If yes, please explain: ____

So that we may provide you with a custom treatment plan designed to meet your interests, please check all that apply:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do you grind your teeth at night or during the day?
- ☐ Do you snore or suffer from sleep apnea?
- ☐ Do you have discomfort in your jaw or headaches?
- ☐ Do you have sensitive teeth?
- ☐ Are you interested in Invisalign?
- ☐ Are you interested in implants to replace teeth?
- ☐ Are you interested in whitening your teeth?
- ☐ Are you interested in sedation dentistry?
- ☐ Are you interested in Veneers or Lumineers?

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: ____
Primary Care Physician's Name: ________________________ Office Phone: ____-____-____
Specialist's Name: ________________________ Office Phone: ____-____-____

Please review the following conditions and check all that apply: (Your answers are for our records only and are strictly confidential.)

- ☐ Heart Murmur
- ☐ Anemia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ HIV
- ☐ Osteoporosis
- ☐ Respiratory Illness
- ☐ Abnormal heart condition
- ☐ Kidney disease
- ☐ Heart attack or disease
- ☐ Venereal disease
- ☐ Psychosis/Psychiatric Care
- ☐ Sore/Enlarged lymph nodes
- ☐ Cancer/Previous Biopsy
- ☐ Other: ________________________________
- ☐ Slow healing mouth sores
- ☐ Other infections
- ☐ Recurrent Illness
- ☐ Joint replacement
- ☐ Glaucoma
- ☐ Abnormal bleeding
- ☐ Liver disease
- ☐ Latex sensitivity

Are you required to pre-medicate (antibiotics) prior to your dental appointment? Yes ☐ No ☐
Have you ever been diagnosed with abnormal blood pressure? Yes ☐ No ☐
What is your normal blood pressure? ____/____
Any history of drug/substance abuse? Yes ☐ No ☐

Are you allergic to or have you had an adverse reaction to:

- ☐ Local Anesthesia
- ☐ Codeine/Other pain reliever
- ☐ Penicillin/Other antibiotics?
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Jewelry/Metal

Do you smoke? Yes ☐ No ☐
How often? ____________________________

Women:

Are you pregnant? Yes ☐ No ☐ Planning on becoming pregnant? Yes ☐ No ☐
Taking birth control? Yes ☐ No ☐

Please list any medications that you are currently taking, including supplements. (If more than four, please provide a list.)
1. ______________ 2. ______________ 3. ______________ 4. ______________

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: ____/____/____

WELCOME TO SANDALWOOD DENTAL!

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 to 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 conformations? Yes ___ No ___

Emergency Contact Information

Name: ______________________
Home Phone: ____-____-____ Cell Phone: ____-____-____ Work Phone: ____-____-____
Relationship to patient: ______________

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? ______________________