



NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Address Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

Emergency Contact

Work Information

Full Name:		Street address:	
Phone number:		City:	
Relation:		State:	
		ZIP:	

Patient's signature:

Date:



PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature:

Date:



FINANCIAL POLICY

Financial Agreement

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. Please note that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment.

Dental Benefits

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. All insurance co-pays and deductibles must be paid at the time of scheduling. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. I realize I am financially responsible for all charges incurred, regardless of insurance coverage.

Payment:

The payment of the estimated patient portion is due at the time of scheduling the treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options: 1) We accept the following forms of payment: Cash, Check, Visa, Discover, Amex, and MasterCard. Checks that are returned to our office from your financial institution are subject to a \$30.00 returned check fee. This fee covers the processing fees that are charged to our office. 2) Third-party financing with Care Credit®. Approval must be received prior to the treatment date.

Appointments:

Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment, so we ask that you kindly give us a minimum of 2 business days notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 2 business days notice, a cancellation fee of \$75 will be applied to your account and if necessary, all future appointments will be canceled and patients will be placed on a "same day list" for their next visit.

Minor Child/Children:

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date.

I have read the Ridgetop Dental Financial Agreement. I understand and agree to this Financial Agreement.

Patient's signature:

Date:



RIDGETOP DENTAL

Cosmetic, Implant & General Dentistry

Ridgetop Dental Reston

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Ridgetop Dental Reston offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Ridgetop Dental Reston will use reasonable means to protect the security and confidentiality of email information sent and received. However, Ridgetop Dental Reston cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Ridgetop Dental Reston and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Ridgetop Dental Reston.

Patient's signature:

Date:



TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Ridgetop Dental Reston, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Ridgetop Dental Reston will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Ridgetop Dental Reston cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Ridgetop Dental Reston and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Ridgetop Dental Reston.

Patient's signature:

Date: