

NEW PATIENT FORM

Basic Information

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

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Records and Radiographs

Please choose one of the options below regarding dental radiographs (X-Rays):	
Do you have a thermography report, or any other lab report from another provider you would like the dentist to review with you?	

Patient's signature:

Date:

PRIVACY POLICY CONSENT

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 the provider at the following address: 1415 State St #800, Richardson, TX 75082:
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 separately from the rest of the clients 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 individuals 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 the 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 individuals 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:

Please tell us which providers we may send reports to regarding your care (ie, physician, pediatrician, naturopath, bodyworker, etc).	
---	--

FINANCIAL AND APPOINTMENT POLICIES

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. FULL PAYMENT may be required to be paid prior to scheduling more lengthy appointments, in order to reserve an extended amount of the doctor's time.

If insurance benefits cannot be verified 2 business days in advance, or if your insurance policy will only send payments directly to you, payment for the full amount of treatment will be due at the time of your appointment.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged \$75 per hour of scheduled appointment time. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature:

Date:

INSURANCE POLICY

If I do not provide Flourish Dental Boutique with my complete insurance information at least 2 business days in advance, if I have Delta Dental benefits, and/or my dental insurance company will not send payments to Flourish Dental Boutique, **I will be required to pay the full amount of my treatment at the time of my appointment.**

I understand that Flourish Dental Boutique is not contracted with any dental insurance company, and all insurance claims are filed as an out-of-network provider.

Patient's signature:

Date:

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. Flourish Dental Boutique 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. Flourish Dental Boutique will use reasonable means to protect the security and confidentiality of email information sent and received. However, Flourish Dental Boutique 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 Flourish Dental Boutique and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Flourish Dental Boutique.

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. Flourish Dental Boutique, 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. Flourish Dental Boutique will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Flourish Dental Boutique 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 Flourish Dental Boutique and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Flourish Dental Boutique.

Patient's signature:

Date:

Occasionally our team will take photos of your teeth and mouth for educational presentations outside of the office. These photos will NOT include the nose or eyes, or easily identifiable features, and will not include your name.	
--	--

X-RAY POLICIES

I understand that recent (within the last 12 months) x-rays are required for dental care in most cases*. These are for clinical, ethical, as well as legal reasons. If I do not wish to take x-rays at my first visit, I will need to send **recent (less than 12 months old)** x-rays to info@flourish.dental at least 2 business days before my appointment. If I do not have recent x-rays before my appointment time, and do not wish to take them at my appointment, I understand that my appointment may need to be changed to a consultation only, and no exam or cleaning may be performed. Information regarding the equipment and radiation levels used, why we have this policy in place, and ways to mitigate the effects of radiation in general, can be found at www.flourish.dental. If I have further questions or concerns, I can call the office before my appointment at 469-676-2777. I understand that taking dental x-rays is a procedure that requires my informed consent, and that I always have the option to decline.

*Exceptions to the x-ray requirement include infants, toddlers, or anyone seeking a limited exam for oral health issues not involving the teeth, bone, or gums.

Patient's signature:

Date: