Premier Family Dental

Office & Financial Guidelines

Our office prides itself on personal patient attention. Dr. Khalil dedicates extra time to his patients so that they are well educated about their dental needs. Therefore, we schedule one patient in an allotted time with Dr. Khalil.

If a situation arises that makes it necessary to change your appointment, we require at least a 48 business hour notice to make that change. We will assess a $35.00 fee for any appointment cancelled or failed in less than 48 hours. We respect our patients' schedules and do all that we can to keep our schedule running on time.

- Patients arriving more than 15 minutes after their appointment time may be rescheduled out of courtesy to our other patients.
- In our office, the parent who brings a child in for his/her appointment is the parent responsible for payment. In a divorce situation, any legal obligations on the part of either parent to pay for dental treatment is to be worked out between the parents.
- Dental procedures require a great deal of attention therefore; only patients scheduled for treatment are permitted in the dental suites. Family & friends are more than welcome to wait in the reception area.
- A $25 treatment deposit is required to secure any restorative appointment. The treatment deposit will be held as a credit on the account until the day of the appointment. All credits will go toward the estimated patient portions, unless cancelled less than 48 hours.
- "Estimated" patient co-pays are due before services are rendered. If additional treatment is performed or lesser treatment is needed than anticipated, we will adjust the payment accordingly. We accept cash, check, MasterCard, Visa, and Care Credit Payment Plans. **Feel free to inquire about our Care Credit payment plan or In-house payment plan options.
- Sedation appointments require: "Estimated" co-payment be paid 7 days prior to appointment. A minimum 7 day notice of cancellation must be given to receive a full refund of payment.
- Delinquent accounts may be subject to late fees, finance charges, &/or collections. The billing policy of our office is to charge a $25.00 late fee for all statements not paid within the 15 day billing cycle.

FILING OF INSURANCE:
In the event your insurance company does not pay what is estimated, you have **2 weeks to submit** your balance from the time the Explanation of Benefits is received. In some instances, insurance companies may send insurance benefits directly to the patient. In these cases, patients are given ten (10) days to submit payment to Premier Family Dental from the time an EOB is received.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for services rendered. All charges must be paid within 60 days of the appointment, regardless of insurance. Please keep in mind that your insurance plan is not designed to pay all charges, but simply provides some assistance to you. Your dental insurance benefits are based upon a contract between only your employer and the insurance company. The type of plan your employer has purchased for you determines the amount of coverage.

I hereby acknowledge that I have read and understand the Office Guidelines

Patient -or- Guardian Signature _____ **-Date-**_____

Welcome!

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III DENTAL Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

MEDICAL AND DENTAL HISTORY FORM

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that benefits your overall health and well-being.

Within the past year, have there been any changes in your general health?

Yes ____ No ____

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name and address: _____

Please mark any of the following to indicate YES in response to the question:

____ Have you ever taken pre-med prior to dental visits?

____ Are you currently under the care of a physician due to a specific condition?

____ Have you been hospitalized within the last 5 years due to a surgery or illness? Please specify.

____ Are you currently taking any prescription or non-prescription drugs? Please specify.

____ Do you use tobacco (smoking or chewing)?

____ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

____ Do you have dental anxiety?

If any of the previous questions are marked, please explain:

_____

WOMEN ONLY: Are you pregnant or nursing?

Yes ____ No ____

Please indicate if you have experienced any of the following:

____ Allergies	____ Anemia	____ Arthritis
____ Artificial Joints	____ Asthma	____ Back Problems
____ Birth Control Pills	____ Blood Disease	____ Blood Thinner
____ Breast Implants	____ Cancer	____ Chemotherapy
____ Codeine Allergy	____ Cough, Persistant	____ Diabetes
____ Dizziness	____ Epilepsy	____ Excessive Bleeding
____ Fainting	____ Glaucoma	____ Hay Fever
____ Head Injuries	____ Headaches, Migraines	____ Heart Murmur
____ Heart Problems	____ Hepatitis	____ High Blood Pressure
____ HIV/AIDS	____ Jaundice	____ JAW PAIN
____ Kidney Disease	____ LATEX Allergy	____ Liver Disease
____ Mental Disorders	____ Mitral Valve Prolapse	____ Nervous Disorder
____ Pacemaker	____ Penicillin Allergy	____ PRE-MED
____ Radiation Treatment	____ Respiratory Problems	____ Rheumatism
____ Seasonal Allergies	____ Siezures	____ Sinus Problems
____ Skin Rash	____ Stomach Problems	____ Stroke
____ Sulfur Allergy	____ Taking Medications	____ Thyroid Problems
____ Tobacco Habit	____ Tuberculosis	____ Tumors
____ Ulcers	____ Venereal Disease	

Do you have any other health issues or allergies?

What is the reasons for your dental visit today? _____

When was your last visit to the dentist (if to a different office)? _____

Prior Dentist's name and address? _____

Please mark any of the following to indicate Yes in response to the question:

____ Do your gums bleed when you brush or floss?

____ Do your teeth experience sensitivity to cold or hot temperatures?

____ Are any of your teeth currently causing you pain?

____ Do you grind your teeth (either consciously or during sleep)?

____ Are any of your teeth loose?

____ Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examinations for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____

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 1/1/03, 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 such changes are permitted by applicable law. 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 privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, 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 quality assessment and improvement activities, 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 to use your health information or to disclose it to anyone for any purpose. If you give us an 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 written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

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 you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or 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 judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical 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 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, neglect, 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 others.

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

Appointment Reminders: 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 a format other than photocopies. We will use the format you 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 this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this 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 purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2006. If you request this accounting more than once in a 12-month 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 disclosure 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 about your health information by alternative means or to alternative locations. You must 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 location you request.

Amendment: You have the right to request that we amend your health information. Your 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 a Web site 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 us.

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 if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: **Betsy Tabatcher**

Telephone: **(330)334-7645**
Fax: **(330)335-2322**

Address: **675 High Street Suite A**
Wadsworth, OH 44281

Premier Family Dental
DR. SHAHIR KHALIL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices (see in-office clipboard)

_____ _____

-Signature- -Date-

I authorize Premier Family Dental, regarding anything pertaining to dental treatment, to:
Speak to the following people:

Spouse _____

Other (s) _____

-For Office Use Only -

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please specify)

_____