Silverstone Dental

Confidential Patient Information

Please print legibly and fill in to the best of your knowledge.

Personal Information

Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Referred By: _____

Person Financially Responsible For The Account

Name: _____ Relationship: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Dental Insurance Information

Primary Insurance Co: _____

Insurance Co Address: _____ Ph# _____

Employee: _____ Relationship: _____ SSN: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____ Ph# _____

Insurance Co Address: _____

Employee: _____ Relationship: _____ SSN: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any third-party involvement

_____ _____

Patient Signature **Date**

Silverstone Dental

Confidential Patient Information II

Please print legibly and fill in to the best of your knowledge.

Health Information

Personal Physician Name: _____

Personal Physician Address: _____

Yes No 1.) Have you been hospitalized within the past 2 years? For what? _____

Yes No 2.) Are you currently being treated by a physician? For what? _____

Yes No 3.) Are you currently taking any medications or drugs? Please list _____

_____

Yes No 4.) Have you received counseling for excessive use of alcohol or drugs?

Yes No 5.) Are you allergic to any drugs? Which ones? _____

Yes No 6.) Have you ever had a skin rash or other reaction to metal jewelry? _____

Yes No 7.) Are you allergic to any metals? _____

Yes No 8.) Do you bleed excessively upon injury?

Yes No 9.) Are you pregnant?

Yes No 10.) Have you ever been involved with dental or medical legal activity?

Circle Any of the Following Conditions That You Have Had or Have Now

a. AIDS/HIV
b. Arthritis
c. Asthma
d. Cancer
e. Diabetes
f. Epilepsy
g. Glaucoma
h. Heart Murmur
i. Heart Problem
j. Hepatitis
k. High Blood Pressure
l. Jaundice
m. Kidney Problems
n. Low Blood Pressure
o. Nervous Break Down
p. Psychiatric Therapy
q. Osteoporosis
r. Rheumatic Fever
s. Sexually Transmitted Disease
t. Stroke
u. Tuberculosis
v. Other Disease:
_____
_____

Person to be Contacted in Case of Emergency

Name: _____ SSN: _____

Address: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

_____ _____

Patient Signature **Date**

Silverstone Dental

Financial Policies for Patients Without Insurance

Treatment Plans: After your initial appointment, and any other exam that yields need of treatment, a treatment plan will be made available to you with what reestimate your treatment will cost. While we don't recommend waiting on any necessary treatment, we will list the items in order of priority by quadrant of the mouth (i.e. Upper Right (UR), Upper Left (UL) and so on). If there are elective procedures for cosmetic reasons or other non-pathologic treatment options we will place them in an alternate treatment plan. If you have any questions on what treatment is necessary and what is elective please ask us. We ask that you sign this treatment plan to show you've received it only. This is **NOT** consent for treatment, it solely shows that you have been given the suggested treatment and any alternate options that may be available.

Accepted Forms Of Payment: We accept cash, personal checks and credit card payments (American Express, Master Card, Visa and Discover Card). We also accept HSA, Care Credit and Lending Club payment for treatment rendered. We do not offer in-office financing.

Payment at Time of Service: Payment in full is expected at the time the service is rendered. On treatments that require more than one visit (i.e. crowns, etc.) Payment may be broken up 1/2 the total at the first appointment and 1/2 at the final appointment.

Non-payment and Outstanding Balances: We will mail out 2 statements with remaining balances, if no response or contact is made a final notice will be mailed out via priority mail (USPS). Each of these mailings will occur at 1 month intervals. If no contact is made with our office the account will be turned over to an outside collection agency. If we cannot locate you (phone number, email or address change) your account may be turned over to a collection agency as well. Please keep us updated on any changes in your contact information so we can avoid this scenario.

Accounts Turned Over to Collections: If there is no action made on an outstanding account as noted above, it will be turned over to a third party collection agency. All collections and interest fees will be added to the remaining balance prior to sending the account to collections. The collection fee is 40% of the remaining balance. Interest of 21% APR will also be added to the balance. Please contact our office if you have any questions on remaining balances as we prefer not to involve collection agencies.

Cancellation Policies: While we try to be accommodating of true emergencies and unforeseen constraints placed on our patients that may effect their ability to keep appointments, we require a minimum of 24 hours notice prior to a cancellation (as there are many people waiting for appointments). If cancellation is made within the 24 hour window a cancellation fee will be applied in the amount of $50 per hour of scheduled time. For instance; if you were scheduled for 1.5 hours of chair time for a crown and cancelled within the 24 hour grace period you would be charged $75 ($50 x 1.5 hr). Cancellation fees will also be applied for patients that are more than 15 minutes late and the appointment will be rescheduled.

Statements: We send statements on a monthly basis after all insurance payments are collected as described above.

Please select one of the following options for statement delivery:

____ Please send my statement to the email address on file or to this email address: _____

____ Please send my statements to my home mailing address via USPS.

I have read and understand the financial and cancellation policies for Silverstone Dental (Brent J. Nielsen DMD, P.C.)

_____ _____

Patient Signature **Date**

Silverstone Dental

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ have read the agreement above and do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information & Consent Form and any subsequent changes in office policy, with or without notice. I understand that this consent shall remain in force from this time forward. I further understand that Brent J. Nielsen, DMD dba Silverstone Dental may make changes as necessary to reflect updates and changes enforced by HIPAA regulatory agencies.

_____ _____

Patient or Guardian Signature Date