Office Policies and Financial Guidelines

In order for us to provide high quality dental care in a relaxed environment, we want you to understand our office policies. If you have any questions please do not hesitate to ask.

We are committed to the success of your treatment, and we charge what is usual and customary for our area. Payment is expected at the time of service unless other arrangements have been made in advance. We accept cash, Visa, MasterCard, and we offer financing plans. If you are interested in financing treatment, please ask our front office staff for details.

We manage our schedule so that we can provide individualized attention to each patient. This means that your appointment time is reserved exclusively for you, and we are counting on you to be here. We realize that your time is valuable, and we will do our best to respect your time by being ready for you at your appointment time. If you will not be able to make a scheduled appointment, we need at least 24 hours notice so that we can fill your appointment time with another patient... After (1) broken appointment, computer will automatically inactivate your chart. In order to reactivate your chart and to schedule another appointment, $50 must be paid.

To help ensure that you cancel within the needed time frame, it is our policy to call you to confirm your dental appointment 2 days before it is scheduled. If you're not there to answer the phone and a message is left asking you to call back and confirm, please be sure to do so. If you receive the message after office hours, please call the office number and leave your confirmation on our voice mail. If we do not hear back from you within the appropriate time frame, the appointment may be given to someone on our waiting list. If the appointment cannot be confirmed due to the phone number being changed or disconnected, it will be cancelled unless you contact us.

Payment is due at the time services are rendered, and we will gladly give you an estimate for each appointment. If you have dental insurance or are a Medicaid or Peachcare patient, please be sure to bring your card to your first appointment. For those patients with dental insurance, we will make every effort to help you maximize the benefits available from your plan. We will be happy to assist you by submitting claim forms to your insurance company.

Please understand that we deal with many different insurance plans in an effort to accommodate our patients. It is impossible for our office staff to be aware of the unique requirements of each and every plan. Your plan may have limitations on the number of visits, x-rays and procedures considered for payment. If you have any questions about whether a procedure will be considered for payment, please contact your insurance carrier before beginning the procedure. **The deductible, your percentage, and any outstanding balance not paid by insurance must be paid by the patient.**

In order to keep our fees reasonable, we cannot extend patient accounts beyond 60 days. A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. At 90 days, we ask that you pay the balance or transfer the balance to our financing company. We will provide all the documentation necessary for you to collect payment from the insurance company. In the rare event that it is necessary to turn your account over to our collections agency, you will be responsible for additional collection fees.

Please be sure to let us know as soon as possible of any address change, insurance change, or change in your medical history. We are here to serve you and want to make your visit to our office a pleasant one.

We hope that you will never experience a dental emergency. However, if you do, we will be here to help you. If your emergency occurs during office hours, please call immediately so that we can schedule a time for you. After office hours, please call the office number and leave a message on our voice mail. The Doctor will be notified and will return your call.

Signature_____

Patient Information

Date_____ How did you hear about our office?_____

Patient_____
Last Name First Name MI Preferred Name

Address_____

City, State, Zip_____

Home Phone_____ Work Phone_____

Cell/Other Phone_____ Social Security Number_____

E-mail Address _____ Best phone # to confirm appointment: Home Work Cell

Sex_____ Age_____ Birthdate_____ Marital Status: Single Married Other

Employer_____ Occupation_____

Name of person responsible for account_____

If you have insurance, please complete this section.

Dental Insurance Company_____ Group Number_____

Policyholder's Name_____ Relationship to patient_____

Policyholder's Address_____

_____

Policyholder's Employer_____ Policyholder's Work Phone_____

Policyholder's SSN:_____ Policyholder's Birthdate_____

Please read and sign below.

Assignment/Release: I, the undersigned, assign directly to Dr. Jamey Chang/Villa Rica Family Dental PC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Dr. Jamey Chang to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date_____ Signature_____

Minor/Child Consent: I, being the parent or guardian of the patient listed above, do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and the administration of fluoride, local anesthetics or nitrous oxide as deemed advisable by Dr. Jamey Chang, whether or not I am present at the actual appointment when the treatment is rendered.

Date_____ Signature_____

Patient Health History

Are you currently under the care of a physician? ___Yes ___No If yes, for what conditions?_____

Are you taking any prescription or over-the-counter medications? ___Yes ___No If yes, please list:_____

_____ Do you smoke? ___Yes ___No

Women: Are you pregnant? ___Yes ___No Are you nursing? ___Yes ___No Taking birth control pills? ___Yes ___No

Do you have any drug allergies? ___Yes ___No If yes, please list:_____

Adverse reaction to any drugs? ___Yes ___No If yes, please explain._____

Do you currently, or have you ever had any of the following? (Please check all that apply.)

___ High Blood Pressure
___ Low Blood Pressure
___ Heart Attack
___ Take aspirin regularly
___ Circulatory Problems
___ Respiratory Problems
___ Asthma
___ Kidney Disorders
___ Hepatitis or Liver Disease
___ Epilepsy/Seizures
___ Bleeding Disorders
___ Stomach Ulcers
___ HIV/AIDS or other immune disorder
___ History or chemical dependency
___ Stroke
___ Diabetes
___ Cancer
___ Radiation Treatment
___ Psychiatric Care
___ Back Problems
___ Arthritis

The following questions relate to the need for antibiotic prophylaxis to prevent a potentially serious infection.

Have you ever been advised to premedicate (take an antibiotic) before dental appointments? ___Yes ___No

___ Congenital heart defect
___ Artificial heart valves
___ Joint replacement
___ Artificial joints
___ Rheumatic fever
___ Previous bacterial endocarditis

If you have had any of the above conditions, but you know that you are not required to premedicate, we will require a letter from your physician verifying that you do not need to premedicate.

Please list anything else we should know about your medical history._____

_____

Do you have any of the following dental conditions? (Please check all that apply.)

___ Periodontal/Gum Disease
___ Bleeding when brushing or flossing
___ Sores or lumps in or near mouth
___ Head, Neck or Jaw Injuries
___ Clenching or grinding your teeth
___ Clicking, popping or pain in jaw joint
___ Bad Breath
___ Sensitivity to cold or sweets

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my dental treatment and/or my overall health. I will not hold Dr. Jamey Chang or her staff responsible for the results of any errors or omissions in the information I have provided on this form.

I have read and understand the Office Policies and Financial Guidelines provided to me, and all my questions have been answered to my satisfaction. I understand that payment is due at the time of service unless other arrangements have been made in advance. I will accept responsibility for all charges not paid by my insurance within 60 days of my visit.

I have read the privacy practices of this office. I have been given a copy of this notice. All my questions about the privacy of my health information have been answered to my satisfaction.

Date_____ Signature_____

Dentistry Patient Management Techniques

It is our intent that all professional care delivered in our dental operations be of the best possible quality we can provide for each child. Providing high quality care can sometimes be very difficult, or even impossible, because of the lack of cooperation of some young patients. Among the behaviors that can interfere with the proper provision of the quality dental care are: hyperactivity, resistive movements, refusing to open mouth/keep open long enough to perform the necessary dental treatment, and even aggressive and/or physical resistance to treatment, such as kicking, screaming, and grabbing at the dentist's hands or the sharp instruments.

All efforts will be made to obtain the cooperation of the child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

Methods Used:

1. **Tell-Show-Do**: The dentist or the assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive Reinforcement**: This technique rewards the child who displays desirable behavior. Rewards include: compliments, praise, a pat on the back, a hug, or a prize.
3. **Voice Control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important that the abrupt or sudden nature of the command.
4. **Mouth Props**: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. **Physical Immobilization by the dentist**: The dentist immobilizes the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements.
6. **Physical Immobilization by the Assistant**: The assistant immobilizes the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements.
7. **Papoose Boards and Pedi-Wraps**: These are immobilizing devices for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in the device and is placed in a reclined dental chair. **IMMOBILIZATION MAY BE USED IF THE PATIENT IS UNCOOPERATIVE OR IF, THE DOCTOR'S OPINION, IT WILL IMPROVE SAFETY FOR THE CHILD AND STAFF.**
8. **Nitrous Oxide**: Nitrous Oxide may be provided for your child. The patient does not become unconscious

If you have any questions about any of the above techniques, please ask.

Note: If you do not agree with the above methods listed, please let us know so that we may talk to you about them. But realize that it therefore may not be possible to complete any dental work for your child in a safe environment.

Privacy Practices

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to explain to you the ways in which we will use and disclose the information about your health that we obtain in the course of your treatment. The privacy of your health information is very important to us, and we will use that information only in ways that we feel are beneficial to your health. Besides using your information to treat you, we would also like to communicate with you to confirm your appointments, send holiday greetings and newsletters about our practice. We will not sell your information or use it for any marketing purposes. If you have any questions, please ask and we will be happy to explain our policies.

Our commitment to your privacy.
Our practice is dedicated to maintaining the privacy of your identifiable health information (PHI). In conducting our business, we must create records regarding you and the treatment services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

We may use and disclose your individually identifiable health information (PHI) in the following ways:

1) **Treatment.** The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may ask you to have an x-ray, and we will use the results to help us reach a diagnosis. Many of the people who work for our practice, including but not limited to the doctors and staff, may use or disclose your PHI in order to treat you or to assist others in your treatment, such as a dental specialist. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.

2) **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer or dental plan to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as a family member. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers to assist in their billing and collection efforts.

3) **Appointments and reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment. For example, we may send appointment reminders and recall cards to remind you of an upcoming office visit by mail, phone, or email.

4) **Non-medical communications.** Our practice may use your PHI to contact you for non-medical reasons. For example, we may send you a thank you card, newsletter or other communication via mail.

5) **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6) **Open Areas.** There are open areas within our office where conversations with you regarding your care may be overheard by others. Every attempt will be made to minimize the exposure of your PHI, and if requested we will locate a private area in our office for our conversations with you.

7) **Release of information to family and friends.** Our practice may release your PHI to a friend or family member who is involved in your care or who assists in taking care of you. For example, parents or guardians may ask a grandparent to take their child to our office for treatment. In that case, the grandparent may have access to that child's medical information.

Signature _____ Date:_____

Smiles-R-US • 1111 Bankhead Hwy • Carrollton, GA 30117 • (770) 214-5555
Villa Rica Family Dental • 865 South Carroll Road, Suite C • Villa Rica, Georgia 30180 • (770) 459-4131

Consent for Treatment of a Minor

In providing dental care, we will treat your child as we would our own. Dentistry is an important health service for your child, and it is our goal to provide him/her with a satisfying experience in our office. Please read this form carefully. Should you have any questions, our office staff will be delighted to help you.

1. I hereby authorize and direct Dr. Chang, associates, and the staff of Smiles-R-Us to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by dental hygienists and assistants other than the dentist.
3. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.
4. In general terms, the dental procedure(s) can include but not be limited to:
    a. Comprehensive oral examination, radiographs, cleaning of the teeth and the application of topical fluoride.
    b. Application of sealants to the grooves of the teeth.
    c. Treatment of diseased or injured teeth with dental restorations, stainless steel or composite crowns, and/or root canal treatment.
    d. Oral surgery, extraction of one or more teeth, excision of hyperplastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
    e. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
    f. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
    g. Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
5. I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child.
6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
7. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
8. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should receive oral medications and/or anti-anxiety agents. I will not hold Dr. Chang or any of her staff responsible for any errors or omissions I may have made. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.
9. I authorize other individuals with whom I have placed the care of my child, such as other family members, caregivers, to sign consent for dental treatment for my child should they bring my child to any future appointments.
10. I authorize Smiles-R-Us to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read & understand this consent & the meaning of its contents. All questions have been answered in a satisfactory manner & I believe I have sufficient information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

_____ _____

Patient's Name Date

_____ _____

Parent or Guardian Relationship to patient

Attention Parents:

On your child's first visit, we allow one parent to come back with the child so that you can meet the doctor, hygienist, and check out the environment in which your child is being treated. Any appointment after that we request that the child comes back by himself because children follow the doctor's instructions better when the parent is not present in the room. This allows the doctor and the clinical team to focus full attention on the child. We will not hesitate to call the parents back when necessary.

Any filling appointment for a child takes 2 hours and for siblings 3 hours because we're on kid's time. Please plan accordingly. In addition please only bring the child that needs treatment due to limited seats in the waiting room. Thanks for your cooperation.

Signature:_____

Date:_____