64 HIGHLAND DENTAL

REGISTRATION

Last Name_____ First Name_____ MI_____

Address_____ City_____State_____ ZIP_____

Home Phone:_____ Work Phone_____Cell Phone_____

Date of Birth:_____ Age_____ Referred By_____

Male ( ) Female ( ) Other ( )

Social Security #_____ Email Address_____

PARENT/GUARDIAN INFORMATION

Last Name_____ First Name_____MI_____

Address_____ City_____State_____ ZIP_____

Home Phone:_____ Work Phone_____Cell Phone_____

DENTAL INSURANCE

	Primary Insurance	Secondary Insurance
Insurance Company:	_____	_____
Group #:	_____	_____
Employer Name:	_____	_____
Insured Name:	_____	_____
Insured Date of Birth:	_____	_____
Insured ID #:	_____	_____
Insured Social Security #:	_____	_____
Relationship to Patient:	_____	_____

Phone: (508) 926-8660
Fax: (508) 926-8667
www.64highlandental.com
64 Highland St
Worcester, MA 01609

64 HIGHLAND DENTAL

GENERAL INFORMED CONSENT

1. EXAMINATION AND X-RAYS: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. CHANGES IN TREATMENT PLAN: I understand that, during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination—the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.

3. DRUGS, MEDICATION, AND SEDATION: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

4. FILLINGS: I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling.

5. CROWNS, BRIDGES, VENEERS AND BONDING: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

6. DENTURES – COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

7. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal treatment will save a tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

64 HIGHLAND DENTAL

8. PERIODONTAL TREATMENT: I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

9. REMOVAL OF TEETH (EXTRACTION): I understand that if a tooth is not savable by root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand that the following are some risks involved in having teeth removed: pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

10. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ): I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the jaw(near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, and the cost of which is my responsibility.

CONSENT: I have read and understood the above information. Further, I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

Print Name:_____

Signature:_____ Date:_____

Phone: (508) 926-8660
Fax: (508) 926-8667
www.64highlandental.com
64 Highland St
Worcester, MA 01609

64 HIGHLAND DENTAL

FINANCIAL POLICY AGREEMENT

If you have insurance, it is your responsibility to understand your insurance and what dental procedures your insurance will and will not pay for. At 64 Highland Dental, we will work to help you better understand your insurance, but any estimates made by this office to calculate your insurance benefit is only that of an estimate. We will make good faith estimates and defer billing for up to 60 days. We will file the appropriate forms with your insurance company. If your insurance denies coverage, or if we do not receive payment within 60 days from the date of services rendered, that amount will then become due and payable by you, regardless of any estimates given to you by this office. Please remember that your coverage is a contact between you and your insurer and/or employer. Although we make every effort to help you obtain and understand your benefits, we cannot guarantee what your insurance will pay.

Your portion of the fees for treatment is due at the time treatment is rendered.

I acknowledge my responsibility for payment of services rendered by 64 Highland Dental in accordance with 64 Highland Dental fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part, or none of the charges.

If the balance on your account is not paid within 60 days of statement date, your account will become delinquent and will be forwarded to a third-party collection agency. If this becomes necessary, additional fees may be added to cover handling charges. If your account falls delinquent longer than 60 days, an interest rate of 5% will be charged to your account every 90 days.

I authorize payment to be made directly to dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information to my insurance carrier. This agreement becomes effective on the date of the first appointment at 64 Highland Dental.

You have the right to request copies of your dental records and X-rays. There is a fee of $50 for records and/or X-rays. We are licensed by the MA Board of Radiology to take radiographs, and are required, by law, to keep all original copies of your dental records.

All appointments have specific date, time, and length of stay so that you are more efficient with your time here. With this in mind, we have developed a cancellation policy that is for both our patients and our practice. Late cancellations (less than 48 hours prior to appointment), failed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule, we request 48 hours' notice of cancelation or rescheduling of appointments. In the instance of a late cancelation or a failed appointment, there may be a $30 charge per hour of scheduled appointment.

I have read the Financial Policy Agreement and understand my responsibilities to 64 Highland Dental.

Print Name:_____

Signature:_____ Date:_____

Phone: (508) 926-8660
Fax: (508) 926-8667
www.64highlandental.com
64 Highland St
Worcester, MA 01609

64 HIGHLAND DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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.

64 HIGHLAND DENTAL

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.

Authorization and Signature: I authorize the release of my confidential protected dental information to carry out treatment, payment, or health care operations. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Print Name:_____

Signature:_____ Date:_____

Phone: (508) 926-8660
Fax: (508) 926-8667
www.64highlandental.com
64 Highland St
Worcester, MA 01609