Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When your appointment is made the room is reserved and special instruments are prepared for your visit. When there is no notice we do not have the proper amount of time to notify a patient in pain or other patients that would like to take the appointment.

Our policy is as follows:

We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within 24 hours, this is considered a missed appointment.

A $60.00 dollar deposit will be required to hold your next appointment.

The deposit will serve as a credit in your account and will go towards services performed at your next appointment time. If your appointment is 2 or more hours long or more, you will be required to pay your portion for your appointment before rescheduling.
If you are uninsured you will be required to pay half of the total cost of service.
The deposit fee cannot be billed to your insurance company and will be your direct responsibility.

Please understand that if the next appointment is missed, the amount placed for a deposit will be taken from your account. If appointments are still missed after 3 scheduled appointment failures, we will not be able to place you on the schedule in advance. **YOU WILL ONLY BE SEEN ON A SAME DAY BASIS.** Please be courteous.

I have read and understand the Appointment Cancellation Policy of the practice and understand that I must give a minimum of 24 hours notice.

I, _____ (print name), have received a copy Appointment Cancellation Policy.

_____ _____

Signature of Patient Date

Consent for Administration of Local Anesthetic for Dental Procedure(s)

Patient Name_____

Birthdate_____

Please read the following regarding the use of use of local anesthetic in your dental care, and after all your questions have been answered by the dentist and/or his office staff regarding this subject, please sign and date this page as provided below.

Topical anesthetics are applied to mouth tissues with a swab to prevent pain on the surface level. Your dentist may use a topical anesthetic to numb area in preparation for administering an injectable local anesthetic.

Injectable local anesthetics prevent pain in a specific area of your mouth during treatment by blocking nerves that sense or transmit pain and numbing mouth tissue. They cause the temporary numbness often referred to as a "fat lip" feeling. Injectable anesthetics may be used in such procedures as filling cavities, preparing teeth for crowns, treating periodontal (gum) disease, extractions, or root canal therapy. Most dental procedures require up to two, and occasionally more, injections of a local anesthetic. Also, most anesthetic solutions are bitter, and this will be tasted if there is leakage from the injection site(s).

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

I understand that although local anesthetic is extremely safe, some rare or more serious complications may occur secondary to the administration of local anesthesia.

I understand that the most common complications that may occur while the administrating of local anesthetic in dentistry include, but are not limited to, ecchymosis (oral/mouth bruising) and analgesthesis, evidenced by pain, swelling and/or bruising. The rare and more serious complications are paresthesia or permanent anesthesia (permanent numbness or abnormal sensation), and in rare cases life threatening life threating conditions.

I understand that more than one injection and more than one type of anesthetic may be needed to achieve a satisfactory or desired result for treatment purposes at any one appointment.

I understand that dentistry is not an exact science and that dental practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had a full opportunity to discuss and ask questions regarding my treatment, and all questions have been answered to my satisfaction.

Signature of Patient, Parent, Guardian or Personal Representative **Date**

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Todays date _____

Patient's name _____ Birth Date_____ SSN_____

Home phone _____ Cell phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Email adress_____ Employer _____

Spouse Name _____ Birth Date: _____ SSN: _____ Phone Number: _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance

Policy Holder Name_____ Date of Birth _____ SSN _____

Dental Insurance Company_____ Member number_____ Group number_____

Covered by a Secondary Policy? ❑ yes ❑ no

Secondary Policy Holder Name _____ Date of Birth of the secondary policy holder _____

Dental Insurance Company_____ Member number_____ Group number_____

SSN of the secondary policy holder _____

EMERGENCY CONTACT INFORMATION: Name _____ Cell phone _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check and circle any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ **May be pregnant**
  Expected delivery date: _____
- ❑ **Taking hormones or contraceptives**

Name of your previous dentist:_____

Do you have any disease or not listed above?_____

Please list all current medications: _____

Whom may we thank for referring you to our office? _____ ❑ Phonebook

Signature of patient _____ Date _____

Ryan A. Walker, D.D.S.

Payment Options & Financial Agreement

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception- **DENTAL INSURANCE WAS NOT DESIGNED TO PAY FOR ALL DENTAL CARE.** Most contracts have limits and/ or various degrees of co-payment. Since **WE ARE NOT IN NETWORK**, benefits obtained by phone are not reliable, therefore we can only ***estimate*** the amount your insurance will pay.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR) are governed by the **premiums paid**. They have nothing to do with the actual charges. Our fees are based upon the combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay it is what is dentally necessary; **your treatment should not be governed by your insurance contract.**

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility. Any services unpaid by insurance will after 60 days will become your responsibility. Balances left unpaid for 90 days will be turned over to collections.

Patients who are uninsured bear full financial responsibility. There will no payment plans offered after services are rendered. We can only offer you to pre-pay or interest free financing through Care Credit.

All services are to be paid at the time of service.

As a courtesy we will gladly hold a debit or credit card on file for any underpayment by insurance. We accept Cash, VISA, MASTER CARD, DISCOVER AND AMERICAN EXPRESS.

_____ Card Number _____ Expiration Date

- VISA
- Discover
- Master Card
- American Express

If you do not wish to place a card on file please sign to show that you understand your financial responsibility.

_____ _____

Signature Date

24 Hour notice is necessary to cancel appointments. Please understand there is a charge for missed appointments. When your appointment is made the room is reserved and special instruments are prepared for your visit. When there is no notice we do not have the proper amount of time to notify a patient in pain or other patients that would like the appointment. Please be courteous.

HIPAA- Notice of Privacy Practice

Ryan A. Walker, DDS

1700 St. Charles St, Houma, La 70360 (985)-851-1633

HIPAA is a federal law developed to provide a standard of protection for your personal and health information. The purpose of the Notice of Privacy Practice is to explain how Dr. Walker may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though our office will always take great care to protect the integrity and confidentiality of your health information, we are required by law to distribute this notice to you and obtain acknowledgement that you have received the notice. We reserve the right to change this policy without notice.

We use and disclose your health information for treatment, Insurance billing, appointment reminders, referrals between other dental profassionals and for health care operations.

I hereby acknowledge that I received the Notice of Privacy Practice.

_____

Signature of Patient / Guardian

Permission to Share Dental/ Medical Information

My Dental/ Medical information may be obtained and exchanged verbally to: _____

Name/ Relationship

_____

Signature of patient

Permission to Bill Your Insurance

All professional services rendered are to be charged to the patient. Necessary forms will be completed and filed to your insurance as a courtesy to you. However, you are responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes the release of information to the insurer or agency for reimbursement and I am responsible for anything they do not cover.

_____ _____

Signature of Patient/ Guardian Date

Patient refused to sign or communication barriers prohibited obtaining acknowledgement _____