PRACTICE AND FINANCIAL POLICIES
FOR THE OFFICES OF DR. RAYMOND HASTON JR.

THANK YOU FOR CHOOSING THE OFFICES OF DR. RAYMOND HASTON JR. AS YOUR DENTAL PROVIDER. THE FOLLOWING IS A STATEMENT OF OUR PRACTICE POLICIES.

MANAGED CARE HAS FORCED US TO RESTRUCTURE SOME OF THE WAYS IN, WHICH WE RENDER OUR DENTAL CARE. INSURANCE COMPANIES ARE MAKING IT DIFFICULT BY MAKING THE RULES FOR ALL OF US. NOT ONLY DO YOU, THE INSURED, NEED TO KNOW THE RULES AND REGULATIONS OF YOUR INSURANCE, BUT OUR OFFICE ALSO HAS TO FOLLOW THEIR RULES IN ORDER TO GET REIMBURSED. THE COST OF PROVIDING DENTAL CARE HAS RISEN DRAMATICALLY WHILE THE FEES WE RECEIVE FROM INSURANCE HAVE GREATLY DECREASED. BECAUSE OF THIS FACTOR, WE HAVE FOUND IT NECESSARY TO CHANGE OUR POLICIES TO OPERATE AS EFFICIENTLY AS POSSIBLE.

FINANCIAL POLICIES

WE MUST EMPHASIZE THAT AS PROVIDERS OF DENTAL CARE, OUR RELATIONSHIP IS WITH YOU, AND NOT YOU'RE INSURANCE COMPANY. WE FILE THE INSURANCE CLAIM AS A COURTESY TO OUR PATIENTS, BUT ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE OF SERVICE RENDERED. NOT EVERY SERVICE IS A COVERED BENEFIT UNDER ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECTS CERTAIN SERVICES THEY WILL NOT COVER. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND YOUR DENTAL INSURANCE POLICY AND ITS REQUIREMENTS FOR COVERAGE INCLUDING PREAUTHORIZATION OF SERVICES. WE CURRENTLY SEND CLAIMS TO OVER 1000 PLANS AND ARE NOT RESPONSIBLE FOR KNOWING THE REQUIREMENTS OF YOUR SPECIFIC PLAN. IF YOU PROVIDE OUTDATED OR INCORRECT INSURANCE INFORMATION, YOU WILL BE RESPONSIBLE FOR ANY DENIED CLAIMS. MOST PLANS HAVE A TIMELY FILING PERIOD SO IT IS IMPORTANT THAT THE INFORMATION YOU PROVIDE OUR PRACTICE IS THE CURRENT AVAILABLE.

WE DO NOT FILE SECONDARY INSURANCES. IF YOU NEED A COPY OF YOUR ORIGINAL CLAIM FOR YOUR SECONDARY CARRIER, PLEASE CALL THE OFFICE AND ONE WILL BE MAILED TO YOU.

PER YOUR INSURANCE COMPANY, YOUR COPAY MUST BE PAID AT THE TIME SERVICES ARE RENDERED. THERE WILL BE A $5.00 FEE IF WE HAVE TO SEND YOU A STATEMENT FOR YOUR COPAYMENT.

CO-PAYS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, DEBIT CARDS, VISA, AND MASTERCARD. IF A CHECK IS RETURNED, YOU WILL BE CHARGED AN NON-SUFFIECIENT FUNDS FEE OF $50.00.

APPOINTMENTS

IF YOU NEED TO RESCHEDULE OR CANCEL YOUR APPOINTMENT, PLEASE GIVE US A 24-HOUR NOTICE. IF A 24-HOUR NOTICE ISN'T GIVEN YOUR INSURANCE COMPANY PERMITS US TO CHARGE PER HALF HOUR FOR A BROKEN APPOINTMENT.

IF WE ARE EXPERIENCING BAD WEATHER, (ICE, SNOW, ETC.) PLEASE CALL OUR OFFICE BEFORE YOUR APPOINTMENT. WE WILL CLOSE IF WE FEEL IT IS NECESSARY FOR THE SAFETY OF OUR PATIENTS AND EMPLOYEES.

PRESCRIPTIONS

WE WILL MAKE EVERY EFFORT TO CALL IN OR WRITE YOUR PRESCRIPTION WITHIN 24-48 HOURS OF YOUR APPOINTMENT. PLEASE HELP BY CALLING OUR OFFICE 24-48 HOURS OF YOUR APPOINTMENT TIME TO REMIND US IF YOU NEED TO BE PREMEDICATED EITHER LEAVE A MESSAGE OR TALK TO US PERSONALLY.

DENTAL RECORDS

WE WILL GLADLY COPY YOUR DENTAL RECORDS FOR YOU AFTER A RELEASE RECORD FORM IS FILLED OUT. THERE WILL BE NO CHARGE TO YOU IF NEW DENTAL OFFFICE ADDRESS IS PROVIDED AND WE SEND THE RECORDS DIRECTLY TO THE NEW OFFICE. WE NEED 10 WORKING DAYS IN ORDER TO EXPEDITE THIS REQUEST. IF YOU ARE HAND CARRYING YOUR RECORDS THERE IS A FEE OF 15.00 DOLLARS PER FAMILY THIS IS BASED ON VIRGINIA CODE 8.01-413B WHICH REQUIRES THAT RECORDS BE PROVIDED WITHIN 15 DAYS.

THE ABOVE IS A SUMMARY OF OUR POLICIES; PLEASE DO NOT HESITATE TO CONTACT US WITH ANY QUESTIONS OR CONCERNS.

YOU HAVE READ AND RECEIVED THE PRACTICE AND FINANCIAL POLICIES OF OUR OFFICES.

SIGNATURE---------- DATE----------

DR. RAYMOND C. HASTON, JR. D.D.S.P.C. AND ASSOCIATES

14393 Hereford Road, Dale City VA 22193
703-670-8400

ACKNOWLEDGEMENT AND CONSENT FORM

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing here:_____(patient's/parent's initials)

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will issue a revised Notice of Privacy Practices containing the changes.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions. If we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____
(Signature)

Name: _____ Date: _____
(Please Print)

Street Address: _____

City: _____ Zip Code: _____ Telephone: _____
(Please Print)

If this Consent is being signed by a personal representative of the patient(s), provide the following information (please print):

Personal Representative's Name: _____

Relationship to and Name of Patient(s): _____

You are entitled to a copy of this Acknowledgement and Consent after you sign it.

PRIMARY DENTAL CONCERN

TODAY'S DATE_____

NAME_____

STREET_____

CITY, STATE, ZIP_____

TELEPHONE_____ DATE OF BIRTH_____

1. HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL VISIT?_____

2. WHICH TOOTH IS IT?
   ___UPPER ___LEFT ___FRONT ___1/2 WAY BACK
   ___LOWER ___RIGHT ___BACK ___CAN'T TELL

3. HOW SEVERE IS THE PAIN?
   ___EXTREME ___THROBBING ___DULL ACHE
   ___CONSTANT ___MILD ___GETTING WORSE

4. IS THERE ANY SWELLING AROUND TOOTH? YES___ NO___

5. DOES THE TOOTH FEEL LOOSE? YES___ NO___

6. IS IT SENSITIVE TO: HOT___ COLD___ BOTH___

7. IS IT SENSITIVE TO: BITING PRESSURE___ SWEETS___

8. IS THERE A FILLING IN THE TOOTH? YES___ NO___
   IS IT? RECENT___ OLD___ BROKEN___ LOST___

9. HOW LONG HAS IT BEEN HURTING?_____

10. ARE YOU TAKING ANY MEDICATIONS? YES___ NO___
    IF YES, WHAT MEDICATION?_____
    _____

REMARKS: (INCLUDE NATURE OF PROBLEM IN PATIENT'S WORDS)

_____

_____

INSURANCE: YES___ NO___

NAME:_____

NEW PATIENT: YES___ NO___

DR. RAYMOND C. HASTON, JR.
14393 HEREFORD ROAD
DALE CITY, VA 22193

DR. RAYMOND C. HASTON, JR.
560 CELEBRATE VA PKWY,STE.107
FREDERICKSBURG, VA 22406

CONSENT TO DENTAL TREATMENT

Patient:_____ Date:_____

I hereby authorize Dr. Raymond Haston Jr., Associate Doctors and Assistants as may be selected and supervised by him/her to provide me with dental treatment.

The nature, purpose and procedures of the proposed dental treatment have been explained to me and I understand them.

The risks, benefits, and possible complications of the proposed treatment, including the risk that such treatment may not accomplish the desired objective, have been fully explained to me.

Should complications occur, I understand other procedures may be necessary.

I have been advised of the advantages and disadvantages of possible alternative treatments and my prognosis if no treatment is received. Any questions I have had regarding the nature, purpose and procedures of the proposed dental treatment have been answered to my satisfaction.

I have had the opportunity to read this form, ask questions, and have had my questions answered to my satisfaction. I hereby consent to the proposed dental treatment.

Signature of Patient or Guardian Date

Signature of Witness Date

PRINT Clearly **Today's Date:**

PATIENT INFO

Last Name:_____ First:_____ MI:_____ Sex: F____ M____

Address:_____ Apt:_____
(Street, City, State, Zip)

Home phone:(____)_____ Cell:_____ **Patient Date of BIRTH**_____

SUBSCRIBER INFO (INSURANCE ACCOUNT HOLDER)

Last Name:_____ First:_____ MI.:_____ Sex: F___ M

Address:_____ **DATE OF BIRTH** _____Apt:_____
(Street, City, State, Zip)

Employer:_____**Work Phone:**(____)_____
Street
Address:_____
(Street, City, State, Zip)

Insurance Co.Name & Address:_____
(Street, City, State, Zip)

I.D.#:_____**Group #:**_____ **Phone:**(____)_____

Name of Nearest Relative Not Living w/You:_____Relationship:_____

Address:_____Phone:(____)_____
(Street, City, State, Zip)

Parent's Name (if patient is a Minor):_____

Emergency Contact:_____Phone:(____)_____Cell:_____

Person Responsible for this Account:_____

I Will Pay By Cash:_____ Check:_____ Charge:_____ Insurance:_____

Responsible Person SSN:_____ **Patient SSN:**_____

Date of Last Dental Visit:_____ Purpose of Today's Visit:_____

Has patient been hospitalized in the last 5 yrs?____ For what?_____
Is patient taking any medications now?_____ For what?_____
Physician's Name:_____ Phone:(_____)_____
Date of patient's last visit to the doctor? _____

Does patient now or has patient ever had *(Please √)*:

	YES	NO
Abnormal Bleeding	_____	_____
Aids..... Yes_____No_____ HIV... Positive	_____	_____
Anemia	_____	_____
Asthma	_____	_____
Diabetes	_____	_____
Epilepsy	_____	_____
Ever taken the diet drug Fen-Phen	_____	_____
Heart Disease	_____	_____
Heart Murmur/Mitro Valve Prolapse	_____	_____
Hepatitis..... Date_____	_____	_____
High Blood Pressure_____ or Low_____	_____	_____
Prosthesis (i.e. Hip or Knee Replacement)	_____	_____
Rheumatic Fever	_____	_____
Tuberculosis	_____	_____
Use any tobacco Products	_____	_____

Does patient have allergies to (*write YES or NO* on line provided):

Local Anesthesia... _____ Metal..... _____
Penicillin..... _____ Latex..... _____

List patient's allergies to *ANY* medications or foods_____

Women: Are you pregnant? ... .**Yes** _____ **No** _____

IN THE EVENT MY ACCOUNT BECOMES DELINQUENT, I UNDERSTAND I AM RESPONSIBLE TO PAY THE ACTUAL AND REASONABLE COLLECTION CHARGES/OR ATTORNEY FEES.

Signed_____ **Date**_____

FAMILY DENTISTRY
14393 HEREFORD ROAD
DALE CITY VA 22193
703.670.8400

DR. RAYMOND C. HASTON, JR DR. LINDA F. JONES

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I [ ] **am** and active duty member of the U.S. Armed Forces.

I [ ] **am not** and active duty member of the U.S. Armed Forces

_____ _____

DATE RESPONSIBLE PARTY