Financial Agreement

Welcome…and thank you for choosing us to provide you with the highest quality dental care in a warm, caring environment. It is important to us that you are perfectly comfortable and clear regarding fees, services, or any other concern. Please don't hesitate to ask us to explain anything whatsoever.

Payment

We accept Visa, MasterCard and Discover
We offer a 5% discount for cash payments, if total treatment plan is paid in full.
We also offer third party financing through Care Credit (Ask our Financial Coordinator)
We require ½ of your payment initially and ½ upon delivery on all major dental treatments
We require payment in full for Saturday appointments
All remaining portions of dental fees must be paid upon receipt of your statement.

Regarding Insurance

It's wonderful that you have dental insurance to help cover part of the cost of your dental care. However we always **recommend** treatment based on your dental needs, not based on insurance coverage. Dental insurance is a benefit used to assist you, not to dictate necessary treatment. We do accept assignment of insurance benefits, **however, we do require your estimated portion of the bill to be paid at the time of service.** Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. If you have insurance for which we are not an in-network provider, you are responsible for any remaining fees after the insurance company has made payment. Regarding Secondary Insurance, we will be happy to file secondary insurance free of charge for you. If you have secondary insurance, please let us know the carrier's information before the primary claim is filed.

Minor Patients

The adult accompanying the minor (under the age of 18) is responsible for full payment of the services provided. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.

Appointments and Cancellations

When we make your appointment, we are reserving that time for you. We ask that if you must change an appointment, please give us at least 24 hours' notice (**48 hours' notice for Saturday appointments)**. This courtesy makes it possible to give your reserved time to another patient who would like it.
There is a $50 charge for not showing up or cancelling less than 24 hours for weekdays/48 hours for Saturdays, for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.
We feel that our patient's time is valuable. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Acknowledgement and Authorization

I have read, understand, and agree to the above policies listed on page 1 and page 2. Regardless of any insurance I may have, I am ultimately responsible for payment of any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Waterview Dentistry. If my account should become delinquent, I agree to pay the costs of collection, including agency fees, attorney fees, and court costs.

_____ Date: _____

Signature of Patient or Parent if Minor (or legal Guardian)

HIPPA Notice of Privacy Practices

Bill Chang, DDS
9245 Virginia Pkwy Ste. 300
McKinney, Texas 75071
(972) 364-5133
Fax: (972) 346-5131

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **December 9, 2013**, and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

A. Use and Disclosure of Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you for treatment, payment, and health care operations. For example:

- **Treatment:** We may disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Health care Operations:** We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will to affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Disclosures To Your Family and Friends: We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, letters).

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications such as intraoral photography, “no cavity club” for children, and telephoned-in prescriptions.

Marketing Health-Related Services: We will **not** use your health information for marketing communications without you written authorization.

B. Use and Disclosure for the Public Need

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

Required by Law: We may use or disclose your health information when we are required by law to do so.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

C. Partially De-Identified Health Information

We may use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you may request a copy of your information in electronic format and we will charge you no more than our cost of preparing the materials. If we maintain your information in paper files, you may request photocopies or copies in another format. We will us the format you request unless we cannot practically and reasonably do so. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. You

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to your request, we will abide by our agreement except in an emergency situation. However, we are not required to agree to these additional restrictions, except that we must agree to a request that we restrict disclosure of your information to a health plan for purposed of payment or health care operations if the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

Amendment of Health Information: You have the right to request that we amen your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Notification of Breach of Unsecured Health Information: Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you have the right to request a paper copy of this Notice. You may make such a request by writing to the address provided at the top of this Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#: _____Email: _____

Spouse's Name & Phone #: _____

Emergency Contact (other than spouse): _____

Primary Dental Insurance: _____ Group #: _____

Subscriber's Name, DOB & SS#: _____

Secondary Dental Insurance: _____ Group #: _____

Subscriber's Name, DOB & SS#: _____

Physician's Name & Phone #: _____

Date of last visit: _____

Previous Dentist & Phone #: _____

Date of last visit: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

Date of last dental visit? _____/_____/_____ Date of last dental x-rays? _____/_____/_____

Reason for last visit? _____

Do you have any concerns about previous dental care or this dental visit? _____

_____

Do your gums bleed? (circle)		Yes	No		
Are your teeth loose? (circle)		Yes	No		
Have you been told you have gum disease? (circle)		Yes	No		
Have you been told you have bad breath? (circle)		Yes	No		
Are your teeth sensitive to? (circle all that apply)	Sweets	Cold	Heat	Pressure	
Have you ever had any pain in your jaw joints (clicking, popping)? (circle)		Yes	No		
Are you happy with your smile? (circle)		Yes	No		

If no, please explain: _____

What would you change about the present condition of your mouth? _____

MEDICAL HISTORY

Please check “yes” or “no” to indicate if you have any of the following:

Abnormal bleeding .....◯ Yes ◯ No

Aids .....◯ Yes ◯ No

Artificial valve or joints .....◯ Yes ◯ No

Asthma .....◯ Yes ◯ No

Blood disease .....◯ Yes ◯ No

Cancer .....◯ Yes ◯ No

Chemical dependency .....◯ Yes ◯ No

Diabetes .....◯ Yes ◯ No

Heart Murmur .....◯ Yes ◯ No

Heart problems .....◯ Yes ◯ No

Hepatitis .....◯ Yes ◯ No

High blood pressure .....◯ Yes ◯ No

HIV .....◯ Yes ◯ No

Kidney disease .....◯ Yes ◯ No

Liver disease .....◯ Yes ◯ No

Mitral valve prolapse .....◯ Yes ◯ No

Nervous problems .....◯ Yes ◯ No

Pacemaker .....◯ Yes ◯ No

Psychiatric care .....◯ Yes ◯ No

Respiratory disease .....◯ Yes ◯ No

Rheumatic fever .....◯ Yes ◯ No

Tuberculosis .....◯ Yes ◯ No

Do you smoke or use other tobacco products? ◯ Yes ◯ No

Women only: Are you pregnant or possibly pregnant? ◯ Yes ◯ No

Do you have any history of medications for osteoporosis? _____

Please list any medications you are taking: _____

_____

_____

Please check to indicate if you are allergic to any of the following:

Aspirin .....◯ Yes ◯ No

Codeine .....◯ Yes ◯ No

Latex .....◯ Yes ◯ No

Penicillin .....◯ Yes ◯ No

Local Anesthetic .....◯ Yes ◯ No

Please list any other allergies not listed above: _____

Please indicate any other health information you would like us to know: _____

_____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PERMISSION TO DISCUSS DENTAL TREAMTENT

In the event that you may want a **family member or friend** to discuss our dental treatment with our office, we must have permission/consent in writing from you to do so. In section "**A**" please list any person you give Waterview Dentistry permission/consent to discuss your information such as x-rays, account information, treatment, etc.

If you do not wish to give consent to any person, please check section "**B**" below, sign and date the bottom portion of this form. You must choose one option.

****If the patient is a minor, we will discuss dental treatment with either parent or guardian****

A. _____ I hereby give permission/consent to Waterview Dentistry to discuss any and all dental information with the named individuals below.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

B. _____ I do not wish Waterview Dentistry to discuss any of my dental treatment with anyone other than me.

Health Insurance Portability & Accountability Act-HIPPA

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____