



South Shore DENTISTRY

Comprehensive. Compassionate. Convenient.

WELCOME!

Patient Information

Patient Name _____ MI _____ Preferred Name _____

Gender _____ Social Security # _____ Birth Date _____

Family Status Married Divorced Single Child Partner

Phone (Home) _____ Work _____ Cell _____

E-Mail Address _____

Address _____ Apartment # _____

City _____ State _____ Zip Code _____

Employment / School Information

Employer / Union Name _____ Occupation _____

Address _____ City _____ State _____

Zip Code _____ Phone # _____

Student Full Time Part Time School Name _____ State _____

Emergency Contact Information

Name _____ Phone _____

Responsible Party Information

Name _____ Relationship to Patient _____ Gender _____

Social Security # _____ Birth Date _____

Phone _____ Work _____ Cell _____

Email Address _____

Address _____ Apartment # _____

City _____ State _____ Zip Code _____

Patient Name _____

Referral Information

Whom may we thank for referring you to our practice? (Patient, Relative, Facebook, Website, Doctor, Other)

Name of person or referring office name _____

Dental Insurance Information

Primary Dental Insurance

Name of Insured _____ MI _____

Is insured a patient Yes No Insured's Birth Date _____ Relationship to Patient _____

Insured's Address _____

Insured's Employer Name _____

Employer Address _____

Name of Insurance _____

ID # _____ Group # _____

Insurance Address & Phone number _____

Secondary Dental Insurance

Name of Insured _____ MI _____

Is insured a patient Yes No Insured's Birth Date _____ Relationship to Patient _____

Insured's Address _____

Insured's Employer Name _____

Employer Address _____

Name of Insurance _____

ID # _____ Group # _____

Insurance Address & Phone number _____



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Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients are responsible for all the balances regardless of having dental insurance or not. Returned checks are subject to a returned check fee.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Patients with insurance understand that insurance may not cover your appointment cost and are solely responsible for its payment in full. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Balances over thirty (30) days become the sole responsibility of the patient, even if insurance benefits are expected, and are subject to finance charges. A service charge of 1.5% 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.

I understand that the fee estimate listed for dental care can only be extended for a period of four months from the date estimate is made.

I am aware the office requires two full business days' notice for any changes in schedule. Those not following this policy will be subject to a cancellation fee.

If I have dental insurance I give permission for the office to submit for payment on my behalf.

I give permission to discuss my account with the responsible party and other necessary professionals.

I have read the above conditions of treatment & payment and agree to their content.

Patient Name _____

Signature _____ **Date** _____

Signature of guarantor of payment/ responsible party _____

Relationship to Patient _____



Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability Act of 1996 (HIPAA) is a Federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. The act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse protected health information.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health, or condition and related health care services. This Notice takes effect January 1, 2015, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice a any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use your health information to provide you with our professional services. We have established 'minimum necessary or need to know' standards that limit various staff members' access to your health information according to their primary job function. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may use or disclose your health information to a physician or other healthcare provider providing treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances, this can include collection agencies, attorneys, or family members.

Emergencies: We may use or disclose your health information to notify or assist in the notification for a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We may use and disclose your health care information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities, and insurance operations.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/ infection exposure and to prevent and control disease, injury and/or disability.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare 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 not 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.

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

Required by Law: We may use or disclose your health information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal official health information required for lawful intelligence, counterintelligence and other national security activities.

Appointment Reminders: We may use or disclose our health information to provide you with appointment reminders, including, but not limited to voicemail messages, emails, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to look at or get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may obtain a form to request access by using the contact information listed at the end of the Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, you will be charged \$2.00 for each page and a fee of \$20.00 per hour for the staff time needed to make the copies. You will be made aware prior to mailing the copies if you will be charged for postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting you will be charged \$2.00 per page and an administrative fee of \$20.00 per hour while the information is put together.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency). Please contact our Privacy Office if you want to further restrict access to your health care information. Restriction requests must be submitted in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must be in writing, and must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information if you feel it is inaccurate or incomplete. Your request must be in writing, and must include an explanation of why the information should be amended. We may deny your request under any certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

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 Privacy Offer's contact information listed at the end 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 the 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.

Privacy Officer: Owner/ OM

Telephone: 781-331-3030

Fax: 781-335-5878

**Address: South Shore Dentistry
851 Main Street, Suite 8
South Weymouth, MA 02190**



Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatment, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referral to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. Treatment to be Provided

I understand that my course of treatment may require multiple examinations or procedures. It could include, but is not limited to, hygienist/dentist examinations, preventive services, periodontal care (gum care), and restorative treatment (fillings), crowns (caps), and implant or bridge treatment (to replace missing teeth).

2. Drugs and Medications

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

3. 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 the teeth that were not discovered during initial examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. Billing

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Print Patient Name _____

Patient Signature _____ Date _____



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Financial Policy

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in dentistry today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by indicating so below.

Payment of your portion of the charges, whether a part of or the total amount, is due the date service is scheduled, unless other specific arrangements have been made prior to treatment. In many circumstances the patient's estimated balance **must** be paid in full at least **two weeks prior** to scheduled appointment date. If arrangements have not been made, the appointment will be cancelled one week prior. This applies to all family members who are part of your account. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available upon request and approval.

Returned checks are subject to a \$45.00 fee. Balances over thirty (30) days old become the sole responsibility of the patient, even if insurance benefits were expected, and are subject to finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

By signing this document, I understand and agree to the terms described herein. In the case of default of payment, I am responsible to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I also give consent for my account to be discussed with the guarantor/responsibly party attached to my account, even if I am over 18 years of age.

Assignment of Benefits: I authorize the dental benefits otherwise payable to me to be paid directly to Dr. Burt.

Print Patient Name _____

Patient Signature _____ Date _____



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Cancellation Policy

We greatly respect your time and make every effort possible to keep you from waiting. To achieve this, we schedule our time according to the amount needed to serve you and do not participate in overbooking. In order to do this, we must have your respect for our time; therefore we do have a cancellation policy regarding scheduled appointments.

When a patient misses an appointment, staff sits idle. Finding someone to fill this open time is not always possible. This unnecessarily increases the cost of dental treatment. We believe you would rather invest our resources more efficiently to treat you.

Keeping that in mind, we require a minimum of **2 business days notice** to cancel or reschedule an appointment. This notice needs to be given during regular office hours to ensure that you do not incur a charge for that appointment. We are unable to accept voice messages to cancel appointments. Our hours are: Monday & Tuesday 8:00am to 5:00pm, Wednesday 8:00am to 4:30pm, Thursday 7:00am to 6:00pm, and Friday 9:00am to 4:00pm. Our ultimate goal is to serve another patient during that time and not to charge you.

The fees for missed or cancelled appointments that do not adhere to the above guidelines are as follows:

Hygiene visit \$125/ per appointment

Doctor visit \$150/ per hour

Unfortunately, your insurance will not cover these charges so please help us help you not to receive a charge for a missed appointment by following these guidelines. Thank you.

I, _____, have read and understand South Shore Dentistry's cancellation policy. I also understand that a copy of this policy will be provided to me if I ask for it.

Print Patient Name _____

Patient Signature _____ **Date** _____



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Payment Options

Your dental and oral health is the most important concern of ours. Accordingly, assisting you in ways to accomplish needed treatment is important also.

In an effort to help our patients find financial solutions to the cost of dentistry, this sheet is for your information regarding financing options that we have available to you. We hope you will find them of assistance.

1. Lowest Monthly Payment- Outside Financing
 - No initial payment
 - Payments ranging from 18-60 months with affordable payments, which includes a low fixed rate of interest, depending on the terms selected and your credit rating.
 - Prepayments can be made any time without penalty.
 - Fast, confidential approval by phone or online at their secure website
 - Good credit standing required

2. 12 Month interest free
 - 12 monthly payments, interest free (\$1,500 minimum)
 - Good credit standing required

3. We accept all major credit cards
 - Visa
 - MasterCard
 - Discover
 - American Express

If you would like more information on any of these services, please do not hesitate to ask.



REGARDING YOUR DENTAL INSURANCE

To our patients:

During the past decade dental benefits, commonly referred to as dental insurance, have become an integral part of health care planning for families. Dental benefit plans are typically offered to employees or members through companies, unions, and associations and may vary considerably from one plan to the next. The range of benefits depends entirely on what the employer/organization wishes to offer its employees and members. Plans can cover from 0 to 100% of dental services and can exclude certain types of services, such as orthodontics, but can also cover a full range of dental services.

Most benefit plans base their coverage amounts arbitrarily. For this reason, you may receive a lower percentage of the reimbursement level indicated in your dental plan. For example: If your plan states that it will pay 80% of the cost of dental treatment, it means 80% of the fee arbitrarily determined by the benefit plan company and not our actual fees.

Additionally, dental insurance plans should not be labeled insurance. Insurance is when you need coverage (fire, auto, home, health) the insurance company pays the lion's share and you pay relatively minimum copay. Insurance protects you. Dental insurance was first created in 1967 with an annual cap of \$1,000.00. In 1967 a crown for a tooth was charged out on average of \$90.00. Today most crowns are between \$1600.00 and \$2300.00 and the average annual maximums are between \$1000.00 and \$1500.00. I couldn't agree more that your dental "insurance" is somewhat slightly above nonexistent. It is more of a copay or assistance, and nothing like insurance.

As the number of patients covered by dental benefit plans have increased certain assumptions have become evident. I would like to make the principles of my practice as well as the type of service and care we provide our patients very clear.

The type of treatment you need and receive from our team is based upon our professional judgements and not on your coverage by a dental benefit plan. As a courtesy to you, my team will be happy to complete the dental claim form and wait for the expected payment from insurance for up to 30 days. Please provide us with current and accurate information. The total financial obligation however is your responsibility.

If you receive a communication from your plan carrier suggesting that our fees are over and above the usual and customary rate for the services provided to you, please do not accept this as true without first discussing the matter with me. The benefit plan carrier's fee date may be extremely out dated. Please remember that it is not the companies' best interest to update their fees.

We have no contract with your benefit plan company. We are a third party. Therefore your communication with your employer and insurance company in resolving unpaid claims or treatment that is compromised is very important. If after our discussions you believe that the dental benefits provided by your plan are inadequate, you may want to discuss the matter with your employer (HR), union, or association so that the appropriate alternatives can be investigated.

My fees are based on the overhead necessary to run a top quality practice with state of the art equipment, quality team, materials, and advanced continuing education for the staff as well as the doctors so that we may continue to provide our patients the highest level of dental health.

Remember we will help in any way to facilitate a smooth process. No question is too small, whether it is regarding your treatment, benefit plan, or statement. We look forward to your next visit with us.

Sincerely,

Larry D. Burt, DMD