White Dental Spa
3878 Oak Lawn Ave. Suite 310, Dallas, TX 75219
(214) 484-1064
whitedentalsmile.com

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature: Date:

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PRIVACY POLICY CONSENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW THE PATIENT CAN GET ACCESS TO THIS HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF HEALTH INFORMATION OF THE PATIENT IS IMPORTANT TO US. THIS NOTICE IS TO BE GIVEN TO THE PATIENT AND THE PATIENT MAY KEEP IT.

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 the 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 will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at 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 DISCLOSURE 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 dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment: We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of

our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders: We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to tell you about treatment options or alternatives or health related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends: We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Disclosure to Business Associates: We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions

on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Disclosures Required by Law: We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities: We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability;

reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities: We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions: We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes: We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their

duties.

Organ, Eye and Tissue Donation: We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes: We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy

Board.

Serious Threat to Health or Safety: We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or

safety.

Specialized Government Functions: We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation: We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

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 the provider at the following address: 3878 Oak Lawn Ave. Suite 310, Dallas, TX 75219:

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 may request to access and review a copy of your health

information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information. 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 separately 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.

8. You have a right to an accounting of the disclosures of your protected dental information by the 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.

9. Right to Amend: If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect

or incomplete.

10. Right to Restrict Use and Disclosure: You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

11. Right to Confidential Communications, Alternative Means and Locations: You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

12. Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

13. Right Right to Receive Notification of a Security Breach: We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information. The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and

(3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

QUESTIONS AND COMPLAINTS

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

PRIVACY POLICY ADMINISTRATOR

E-JAN TUNG

3878 OAK LAWN AVENUE, SUITE 310

DALLAS, TX 75219

214-484-1064

INFO@WHITEDENTALSMILE.COM

Patient's signature: Date:

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FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We appreciate you. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. We file most major insurance forms with the understanding that you, the Patient, assign your rights to the insurance benefits to us in full but we require that patients pay their estimated amount towards the total cost at the start of treatment.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. Professional services are rendered on a cash or cash equivalent basis only and payment is due in full at the time services are rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist. Debit and most credit cards are

accepted. With approved credit, patient may be eligible for third party financing which entitles patients to a revolving charge account upon approval of the application.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

HALF (1/2) DOWN PAYMENT, IF APPLICABLE

I, the Patient, understand that if the services rendered to me consist of removable appliances, crowns, bridges, or veneers, then I will be required to pay half (1/2) of the total unit price for each item at the time of impression. The half (1/2) payment serves to help cover some of the costs of the impression taking and dental prosthetic making time (labor), lab fees, materials and overhead. This amount is what I will pay at the impression taking time regardless of any insurance coverage I have. Should I fail to return for the final delivery of product(s) (e.g. removable appliances, crowns, bridges, veneers), I realize and agree that the half (1/2) payment shall serve as a payment in full for the costs mentioned in the paragraph above and that I shall have no claim to the return of that money. If my return for the final delivery of product(s) is delayed to me, I understand that the fit might not adequate any longer as structures in my mouth can shift over time. In such a case, I might have to pay for new impressions to be made or for a new dental appliance to be made or both. In that case, I will have to pay half (1/2) of the total price again for each new item at the time of impression. If I return as scheduled, I will receive my final product(s) and I shall at that time owe the other half (1/2) payment whether by cash, credit card, check (if allowed), third party financing (if pre-approved) or insurance.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney’s fees, and court costs associated with the recovery of the monies due on the account.

BAD CHECK FEE AND MISSED APPOINTMENTS:

At the office’s sole discretion, the office may assess a bad check fee of twenty dollars ($20.00) for any check that is returned for insufficient fund (NSF) or for stop payment or which is returned unpaid for any other reason. The office may assess a no show fee for any appointment that is scheduled but missed by a patient without a 24 hours prior notice. Unless we receive notice of cancellation 24 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. White Dental Spa offers patients the opportunity to communicate by email. Email communication may include, but is not limited to, the following: sending copies of your dental records, x-rays, treatment plans, insurance benefit estimates, appointment information, pre-op/post-op care instructions, requests for forms related to your care and answering any treatment-related questions you may have.

Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. White Dental Spa will use reasonable means to protect the security and confidentiality of email information sent and received. However, White Dental Spa cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between White Dental Spa and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by White Dental Spa.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. White Dental Spa, offers patients the opportunity to communicate by mobile text messaging. Mobile text messaging communication may include, but is not limited to, the following: sending copies of your dental records, x-rays, treatment plans, insurance benefit estimates, appointment information, pre-op/post-op care instructions, requests for forms related to your care and answering any treatment-related questions you may have.

Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. White Dental Spa will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, White Dental Spa cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between White Dental Spa and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by White Dental Spa.

Patient's signature: Date: