LA | DENTAL
& Med Spa

*Date*_____

*Patient Name*_____

Marital Status: *Single* ☐ *Married* ☐ *Divorced* ☐ ***Widowed***

*Birthdate*_____ *Age*_____ *Sex* ☐ **M** ☐ **F** ***SS Number***_____

*Street Address*_____

*City*_____ *State*_____ ***Zip code***_____

Parent/Guardian Name _____ *DOB*_____

*Phone #*_____ *Cell #*_____

Email _____

How were you referred to or find us? _____

Reason for Today's Visit? *Circle as many as applicable*: (*Periodontal Disease*) (*Teeth Grinding*) (*Jaw Pain*) (*Loose Teeth*) (*Sensitivity*) (*DryMouth*) (*Bad Breath*) (*Appearance*) (*Routine Checkup/Cleaning*) (*Other*) _____

EMERGENCY CONTACT

*Name*_____ *Relationship*_____

Phone #_____ *Cell #*_____

INSURANCE INFORMATION

*Insurance Company*_____ *Phone #*_____

*ID #*_____ *Group #*_____

***Subscriber Name* (*if different from patient*)**

_____

*Subscriber Birthdate*_____ *SS Number*_____ *Relationship*_____

ASSIGNMENTAND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with the above-named insurance company and assign all insurance benefits to LA Dental & Medspa for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on insurance submissions and the release of my healthcare information as necessary to process claims and determine benefits. This consent remains in effect while I am a patient at this facility.

Signature of Patient, Parent, Guardian Representative

_____

Please Print Name of Signature of Patient, Parent, Guardian or Personal or Personal Representative

_____

Date _____

_____

Relationship to Patient

HEALTH HISTORY

Patient (printed) name _____ DOB: _____

Please circle "yes or no" to indicate if you have, or have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Shortness of breath	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis Type_____	Yes	No	Special Diet	Yes	No
Bleeding Abnormally	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Swollen Feet/Ankles	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Neck/Glands	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesion	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors	Yes	No
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Cough,Persistant,Bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Weight Loss, severe	Yes	No
Emphysema	Yes	No	Radiation Treatment	Yes	No			

Do you wear contact lenses? Yes No

Taking Birth Control? Yes No

Are you pregnant? Yes No Due date_____ Are you nursing? Yes No

Physician's Name and Phone Number_____

MEDICATIONS

List any medications you are currently taking.

_____

_____

_____

_____

_____

ALLERGIES

Circle allergies listed, or others not listed.

Aspirin Latex

Barbiturates (sleeping pills)

Codeine Local Anesthetic

Iodine Penicillin

Other_____

Patient Signature _____ **Date**_____

_____ _____

Parent or Guardian if Minor Relationship to Patient

Office Policy

Welcome to LA Dental & Medspa, Our goal is to provide exceptional dental care in a welcoming and professional environment. To ensure transparency and mutual understanding, please review the following Office Policy. Your acknowledgment and agreement are required prior to treatment.

1. **Full Payment/Co-Payments**: Payment for services, including co-payments and deductibles, is due at the time of service.
2. **Accepted Payment Methods**: We accept cash, and major debit/credit cards.
3. **Financing Options**:We accept many forms of financial payment, including options available through several partnered companies

Deposit Policy

- **Appointment Deposits**: For certain appointments, a deposit may be required at the time of scheduling to reserve your time slot. The deposit will be applied toward the total cost of your treatment.
- **Refunds and Cancellations**: Deposits for appointments canceled with less than 24 hours' notice may be forfeited. Deposits are refundable for appointments canceled with adequate notice or rescheduled according to our policy.

Insurance Policy

1. **Patient Responsibility**: Patients are responsible for co-payments, deductibles, and any services not covered by insurance.
2. **Insurance Information**: Complete insurance details must be provided at the initial visit.
3. **Insurance Payments**: If the insurance company has not paid the balance in full within 45 days, the remaining balance will be transferred to the patient's account.
4. **Non-Covered Services**: Some services may not be covered or considered reasonable under your policy. Patients are responsible for understanding their insurance benefits, deductibles, and coverage limits.

Usual and Customary Rates

Our fees reflect the level of care and expertise we provide and are not dictated by insurance company determinations. Patients are responsible for payment regardless of insurance company assessments of usual and customary rates.

Policies for Adults and Minors

1. **Adult Patients**: Full payment is required at the time of service unless prior financial arrangements have been made.
2. **Minor Patients**: The parent or guardian accompanying the minor is responsible for payment. Non-emergency treatment for unaccompanied minors will be denied unless payment arrangements have been pre-authorized.

Payment Assistance

If you need assistance with financing, we offer flexible payment options .Please contact our office for more information and assistance with applications.

Missed Appointment Policy

1. **Cancellation Fee**: A $75 fee per hour of reserved time applies to appointments canceled with less than 24
2. hours notice.
3. **Repeated No-Shows**: Excessive cancellations or no-shows may result in termination of treatment at our practice.
4. **Weather-Related Exceptions**: Cancellations due to inclement weather will not incur a fee.

Collections

Accounts unpaid after 90 days will be referred to a collection agency, which may negatively impact credit history and limit future treatment at Smile by LA Dental & Medspa.

Acknowledgment and Authorization

By signing below, I acknowledge that I have read, understand, and agree to the terms of the LA Dental & Medspa. I also authorize the release of any necessary information for insurance claims and assign benefits to I certify that I and/or my dependent(s) have insurance coverage with the above-named insurance company and assign all insurance benefits to LA Dental & Medspa for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on insurance submissions and the release of my healthcare information as necessary to process claims and determine benefits. This consent remains in effect while I am a patient at this facility. for services rendered.

Patient Name (Print): _____
Signature (Adult Patient): _____
Date: _____

Parent/Guardian Name (Print): _____
Parent/Guardian Signature: _____
Date: _____

HIPAA CONSENT FORM

Patient Acknowledgment and Consent to Use and Disclose Protected Health Information

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are granted to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This law provides safeguards to my privacy and sets forth regulations regarding the use and disclosure of my PHI.

Specifically, there are rules and restrictions on who may access or be notified of my PHI. These restrictions do not apply to the normal exchange of information necessary to provide me with office services. HIPAA provides certain rights and protections to me as a patient. We balance these needs with our goal of providing you with quality professional service and care.

We have adopted the following policies:

1. **Confidentiality of Patient Information:**
   Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This includes sharing information with healthcare providers, laboratories, and health insurance payers as required for your care.
2. **Storage and Handling of Patient Files:**
   Patient files may be stored in open file racks, and they will not contain any coding that identifies a patient's condition or any information that is not already public record. These files may be temporarily left in administrative areas (e.g., the front office, examination room) but will only be accessible to office staff.
3. **Use of PHI for Appointment Reminders and Communication:**
   We may contact you regarding your appointments via telephone, email, U.S. mail, or any other means convenient to the practice and as requested by you. We may also send you communications about changes in office policies or new technologies that may be of interest to you.
4. **Vendors and Business Associates:**
   The practice may use third-party vendors to conduct business operations. These vendors may have access to PHI, but they are required to comply with HIPAA confidentiality rules.
5. **Government and Insurance Inspections:**
   You understand and agree to possible inspections of the office and the review of documents containing PHI by government agencies or insurance payers in the normal course of their duties.
6. **Concerns or Complaints:**
   If you have concerns or complaints regarding privacy or confidentiality practices, you agree to bring them to the attention of the office manager or the doctor.
7. **No Use of PHI for Marketing:**
   Your confidential information will not be used for marketing or advertising of products, goods, or services.
8. **Access to Your Records:**
   We will provide patients with access to their records in accordance with state and federal laws.
9. **Changes to Policies:**
   We may modify or amend these policies as necessary to better serve the needs of both the practice and the patients. You will be informed of any significant changes to these policies.
10. **Your Rights:**
    You have the right to request restrictions on the use of your PHI and to request changes to certain policies related to your PHI. However, the practice is not obligated to alter internal policies to accommodate such requests.

11. I, the undersigned, have read and understood the terms outlined in this HIPAA Consent Form. By signing below, I consent to the use and disclosure of my Protected Health Information (PHI) as described in this document and acknowledge that I have had the opportunity to ask questions and receive clarification.

I also understand that I may request a copy of this form for my records.

Patient Name: _____
Date: _____

Signature of Patient or Legal Guardian: _____
Relationship to Patient (if signed by someone other than the patient): _____

Consent for Use of Photographs, Videos, and Testimonials

By signing below, I hereby grant LA Dental & Medspa permission to take photographs, videos, and other recordings related to my dental treatment. I understand that these materials may be used for promotional purposes, including but not limited to social media platforms, websites, advertisements, and marketing materials. I acknowledge that these images, videos, or testimonials may be edited or altered at the discretion of the dental office, and I waive any rights to inspect or approve the finished product. I consent to the use of my likeness and personal information related to my dental treatment for marketing and educational purposes, without compensation.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____