Legacy Dental Team Patient Registration

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Birth Date: _____ SSN: _____

Sex: O Male or O Female Marital Status: O Single O Married O Divorced O Separated O Widowed

Address: _____

City, State, Zip: _____

Primary Contact Number: _____ O Home O Cell O Work

Secondary Contact Number: _____ O Home O Cell O Work

Email: _____ *O I would like to receive correspondences via e-mail.*

Previous Dentist: _____ Referred By: _____

Emergency Contact: _____ Emergency Contact Number: _____

Mark all that apply:

O I am the Policy Holder O I am the spouse of the insured O I am the child of the insured

O I am the Responsible Party O I have no dental insurance

Primary Insurance Information

Insurance Company: _____ Member Number: _____ Group Number: _____

Employer Information

Employer Name: _____ Employer Contact Number: _____

OPTIONAL CONSENT TO SHARE DENTAL TREATMENT FOR PATIENTS 18 YEARS AND OLDER:

I WOULD LIKE TO GIVE PERMISSION TO LEGACY DENTAL TEAM TO DISCUSS MY DENTAL TREATMENT PLAN WITH THE FOLLOWING PERSON:

NAME: _____ DOB: _____ PHONE: _____

I UNDERSTAND THAT ALL INFORMATION REGARDING MY DENTAL TREATMENT INCLUDING FEES WILL BE PROVIDED TO THIS INDIVIDUAL FOR ONE YEAR AFTER SIGNING THIS DOCUMENT OR UNTIL I REQUEST TO WITHDRAW THE PERMISSION IN WRITING.

SIGNATURE: _____ DATE: _____

Financial Policy

Patient Name: _____ *Date:* _____

Financial Responsibilities

- I understand that if Legacy Dental team is not contracted with my insurance carrier, I must pay in full at the time of service.
- My payment or co-payment is due and payable at the time services are rendered. I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by Legacy Dental Team may not be covered by my benefit plan. I agree that I am responsible for payment of all services rendered.
- FILLINGS Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling but may downgrade to a silver (amalgam) filling. In this case the patient will be charged the difference. In some cases, the dentist may recommend placing a crown instead of a resin filling.
- DENTURES, PARTIALS, & CROWNS I understand all of the fee is required to be paid on the first visit for treatment.
- MEDICAID/MCNA/FL HEALTHY KIDS/SUNSHINE STATE PLANS/DENTAQUEST (If applicable) I understand Medicaid pays only for limited services. I understand that if I need services which Medicaid does not cover, I am responsible to pay the fees.

Insurance Billing

- As a courtesy, our staff will attempt to verify insurance plan benefits prior to treatment; however, in the event that the dental insurance does not make complete payment for services rendered, each patient is ultimately responsible for the remaining balance within 30 days from billing date.
- Although our staff verifies general dental coverage, there may be certain plan limitations such as waiting periods, frequency limitations, age limitations or non-covered services. ***Verifying your own benefits will help to prevent receiving an unexpected bill after the claim has been processed.***

Predetermination

- For any patient who has a complex treatment plan and will be using insurance, a request for a predetermination of benefits may be made. A predetermination of benefits does not provide the most accurate estimate of payment due; however, it usually takes up to 6 weeks to receive a response from insurance company.

Delinquent Accounts

- Account balances should be paid within 30 days of the account statement.
- Outstanding balance after 90 days will be transferred to a collection agency unless prior arrangements have been made with our front office staff. Patient is responsible for collection agency costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balance.
- Failure to keep account current may result in Legacy Dental Team being unable to provide additional services.

Returned Check

There will be a $25 service fee for any check returned for insufficient funds. When this occurs, we will no longer accept checks as your form payment.

Cancellation of Appointment or No Show

If you are unable to keep your reserved appointment, we ask that you provide our office with at least a 24 hour notice so that your previously reserved time can be given to another patient. If we are given less than a 24 hour notice, it is considered a broken (aka "No Show") appointment and a $25 fee may be charged to your account. AFTER TWO NO SHOWS I WILL NO LONGER BE ALLOWED TO BE PRESCHEDULED AND MUST RESORT TO WALK-IN APPOINTMENTS ONLY AND I UNDERSTAND THAT AVAILABILITY MAY BE LIMITED.

By providing your signature below, you agree that you have

read, understood, and accepted the financial policy.

Signature of Patient/Responsible Party: _____ Date: _____

Legacy Dental Team Patient Registration

NOTICE OF PRIVACY PRACTICES OF LEGACY DENTAL TEAM (HIPAA)

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

Our practice is dedicated to protecting your PHI. We are required by law to maintain the privacy of PHI and provide you with our legal duties and privacy practice practices with respect to PHI. PHI is information about you, including demographic information that may identify you in relation to your condition and related health care services. This notice explains how we may use this information and your rights to access and control your PHI.

We understand that health information about you and your health is personal. We are committed to protecting your PHI. We create a record of the care you receive and maintain it in order to provide you with quality care and comply with certain legal requirements. This notice applies to all of your care generated by this office. This notice will tell you about the ways we may use and disclose your PHI. We also describe your rights to the health information we keep about you, as well as certain obligations we have regarding the use and disclosure of your health information. We are required to: make sure your health information that identifies you is private, give you this notice regarding your PHI, and follow the terms of this notice. You may request a copy of our notice of privacy practices any time.

REVISION OF THIS NOTICE We reserve the right to change the terms of this notice, making any revisions applicable to the entirety of the PHI we maintain. If we revise the terms of this notice, we will post a revise notice at our office and will make paper copies of the revised notice of privacy practice available upon request.

AUTHORIZATIONS We will not use or disclose your PHI for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

YOUR RIGHTS REGARDING YOUR PHI

- You may ask us to restrict certain uses and disclosures of your PHI. We will honor your request when it is legally possible.
- Generally, you may inspect and copy your PHI. This right is subject to certain specific exceptions, and you may be charged for any reasonable fees for any copies of your PHI.
- You may ask us to amend your PHI. We may deny your request for specific reasons. If we deny your request, we will provide you with a written explanation for the denial and the information regarding further rights you may have at that point.
- You have the right to receive the accounting of the disclosures of your PHI that we have during the last six years, except for treatment, payment, or health care operations.

HOW YOUR PHI WILL BE USED AND DISCLOSED

- *Treatment* We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes disclosure to any other dentists to whom you have been referred to ensure they have necessary information to treat you.
- *Payment* Your PHI will be used, as needed, to obtain payment for dental care services. This includes, but not limited to, eligibility in benefits, claims filing, and utilization reviews.
- *Office Operations* We may use and disclose your PHI, as needed, in order to support the business activities of our office. These activities include, but are not limited to, training of staff and quality assessment activities. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign in your name. We may also call you by name in the waiting room when your provider is ready to see you.
- *Appointment Reminder* We may contact you to provide appointment reminder or to request that you call our office for information about your treatment.
- *Disclosure to the Department of Health and Human Services* We may disclose PHI when required by the United States Dept of Health and Human Services.
- *Family and Friends* Your expressed verbal or written authorization is required for disclosure of your PHI to family members, other relatives, or close personal friends that are involved in your health care.
- *Abuse and Neglect* We may disclose your PHI when it concerns abuse, neglect, or violence in accordance to federal and state law.
- *Legal Proceedings* We may disclose your PHI in the course of certain judicial or administrative proceedings.
- *Law Enforcement* We may disclose certain parts of your PHI for law enforcement purposes or other specialized governmental function.
- *Coroners, Medical Examiners and Funeral Directors* We may disclose your PHI to coroners, medical examiners or funeral directors.
- *Public Safety* We may use or disclose your PHI to prevent the decrease or serious threat to the health or safety to another or to the public.
- *Workers Compensation* We may use or disclose your PHI as authorized by law relating to workman's compensation.
- *Business Associates* We may disclose your PHI to a business associate with whom we contract to provide services on our behalf.

QUESTIONS AND COMPLAINTS

Feel free to contact us if you would like more information about our privacy practices or have questions or concerns.

Legacy Dental Team
6651 West Woolbright Road
Suite 116
Boynton Beach, FL 33437
561-600-9293

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ *Date:* _____

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices to review.

Patient Name (Print) _____ Date of birth _____

Signature of Patient/Responsible Party _____ Date _____

Authority of Personal Representative to Sign for Patient (check one):

- ○ Parent
- ○ Guardian
- ○ Power of Attorney
- ○ Other:_____

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

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