Garden Spot Dental Care, PC

office@gardenspotdentalcare.com gardenspotdentalcare.com

101 West Main Street • New Holland, PA 17557 (717)354-3200

PATIENT INFORMATION FORM

Welcome to Garden Spot Dental Care

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

I prefer to be contacted by
☐ Cell Phone ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

Patient Financial and Cancellation Policy
Please read through and sign indicating that you understand our financial and cancellation policy as an insured or un-insured patient.

Insurance Patients:

As a courtesy, any patients with dental insurance will have claims submitted on your behalf to your insurance company with any necessary information. Insurance is not a guarantee of payment. You, as the patient, are responsible for any balance that is not paid to us within 45 days of submission.

-I authorize payment to go directly to Garden Spot Dental Care.
-I authorize Garden Spot Dental Care to submit any dental treatment to my insurance company.
-I authorize the release of any necessary records, this includes clinical notes, x-rays, and photos taken in order to receive payment from my dental insurance company.
-I authorize Garden Spot Dental Care to act as my agent in helping me obtain payment from my insurance company.
-I authorize my electronic signature on all insurance submissions.
-I understand I am financially responsible for all changes whether or not paid by insurance.

Insured and Self-Pay Patients:

-I understand that payment is due at time of service.
-I understand that an unpaid balance will be subject to a 1.75% monthly finance charge after 30 days past due (minimum monthly finance charge of $2.00.)

Cancellation Policy

Dr West as well as our hygienists time is very valuable. A minimum of 24 hours notification to cancel your appointment is required. Failure to give proper notification will result in a cancellation charge. This is NOT covered under insurance and you will be responsible for that charge

I HAVE READ THIS FINANCIAL/CANCELLATION POLICY AND UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY

Signature _____ **Date** _____

HIPAA Acknowledgment

-I understand that I may inspect or copy the protected health information described by this authorization.
-I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
-I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

By signing, I understand the above information and agree with its contents

Signature _____ **Date** _____

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

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○ I consent and accept the risk in receiving information via email

○ I do not want to receive information via email

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. Garden Spot Dental Care, offers patients the opportunity to communicate by mobile text messaging. 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. Garden Spot Dental Care will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Garden Spot Dental Care cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

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○ I consent and accept the risk in receiving information via text messaging

○ I do not want to receive information via text messaging

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

Signature _____ **Date** _____

Response Date: _____