HOPMEADOW DENTAL LLC
714 HOPMEADOW STREET, SUITE 2
SIMSBURY, CT 06070
(860) 658-1234

Financial Consent & Office Guidelines

Financial Obligations & Payment Guidelines

All patients, I understand that any responsibility for payment of services provided in this office for myself and my dependent (s) is mine, due and payable at the time services are rendered regardless of whether I have medical or dental insurance. I am responsible for all fees for services rendered. I am responsible for all fees necessary to collect my account. Any quoted fees will be honored for a period of 3 months. I am aware that any balance carried past 90 days will be subject to interest at 7%, simple interest, and to a 5% rebilling fee at each statement period thereafter, as well as being sent to collections.

Patients with medical or dental benefits: I authorize Hopmeadow Dental LLC and their staff to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to them, and to handle any necessary claim appeal(s) on my behalf. I understand that insurance billing is a courtesy to me by Hopmeadow Dental LLC, and that I have ultimate responsibility for insurance claims, billing and payment of all charges regardless of insurance payment or reimbursement. I understand that it is **MY RESPONSIBILITY to know my specific plan/policy coverage.** If a pre-treatment estimate has been sent to my insurance company, at my request, that this is not a guarantee of payment. I understand that the estimate is based on best available information, but the final charge for which AI am responsible will be based on actual treatment. My dental benefits may cover more or less than estimated, if any, Hopmeadow Dental LLC has the capability to estimate my out -of-pocket cost of treatment based on an estimate of payment from my benefits. Therefore, I understand that payment is expected in full at the time services are rendered, based on this estimate and that the final charge for which I am responsible may change based on treatment and on insurance payment (if any).

Patients without dental benefits: I understand I am required to pay in full at the time services are rendered.

All balances must be paid in full within 90 days to avoid being sent to collections.

Payment Plan Options

Hopmeadow Dental LLC accepts cash, checks, and all major credit cards as forms of payment. Payment plans are offered through our financing company Care Credit. We have partnered with Care Credit to have a variety of options for our patients. A front desk coordinator can assist with the application process in office and brochures are available upon request.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment we require at minimum, a 48-hour notice PRIOR to your reserved appointment for any changes or cancellations and to avoid a $50-$100 cancellation fee per appointment. You may leave a message at any time, bay calling (860)658-1234.We understand that emergencies do occur, and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first occurrence. We record all appointments, cancellations, and no-show appointments and discourage repeats of our scheduling guidelines. If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these guidelines. These guidelines will enable us to better serve the needs of all patients.

By signing below, I have read and understand the above guidelines. I have the right to receive a copy of these signed forms upon request.

_____ _____

Signature of Patient or Guardian Date

HOPMEADOW DENTAL LLC
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SIMSBURY, CT 06070
(860) 658-1234

Patient Name: DOB:

Notice of Privacy Practices & HIPAA Consent

Patient Privacy is important to our practice. We are required by law to maintain privacy of Protected Health Information (PHI) and to provide individual with notice of our legal duties and privacy practices with respect to PHI.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operation
- The Practice reserves the right to change the Notice of Privacy Policy
- The patient has the right to restrict the use of their information
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

This HIPAA Consent/Sharing was signed by (signature) *Todays Date*

_____

Relationship to Patient (if other than patient)

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type _____	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Women:		
Are you pregnant?	☐ Yes	☐ No
Due date _____		
Are you nursing?	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling of Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

_____

Do you wish to talk to the doctor privately about any problem? _____Yes _____No

signature _____ **Date** _____

SIGN & DATE

CONFIDENTIAL PATIENT INFORMATION

PATIENT: _____ DATE: _____
(Last) (First) (Middle)

ADDRESS: _____
(Stteet) (Town) (State) (Zip)

Date of Birth_____ SS No. _____Home Phone_____Cell Phone _____

E-Mail Address _____Marital Status: ___Single _____Married _____Divorced _____Widowed

Place of Employment: _____Occupation: _____

Address: _____
(Street) (City/Town) (State) (Phone No and Ext)

Hobbies: _____

SPOUSE: _____Address if different from above: _____

Place of Employment: _____Occupation: _____

(Street) (City/Town) (State) (Phone No. & Extension)

Person Responsible for Account: _____ Address if different from : _____

Whom may we THANK for referring you to our office(include address if possible): _____

Has any member of your family been treated in our office previously? ___Yes ____No (Relationship)_____

How did you choose our office? _____

DENTAL HEALTH: Please check one: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What priority do you give your teeth (10 being highest)? 1 2 3 4 5 6 7 8 9 10

INSURANCE: **Primary Dental Insurance Carrier** _____

Mailing Address _____

Employee_____SS No. _____Group No._____ Date of Birth _____

Secondary Dental Insurance Carrier _____

Mailing Address _____

Employee_____SS No. _____Group No._____ Date of Birth _____

MEDICAL HEALTH: Please check one: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

MEDICAL UPDATES: I have read my Medical History dated _____ and confirm that it adequately states and present conditions.

Date Exceptions None ☐ Patient's Signature Reviewed By

Have you ever received a blood transfusion: ☐ Yes ☐ No When? _____

HEART SURGERY: ☐ Yes ☐ No When? _____

LIST ALLERGIES: .(ON BACKSIDE OF FORM Hay Fever ☐ etc) _____

DO YOU HAVE: Alzheimer's Disease Yes ☐ No ☐ Hypoglycemia Yes ☐ No☐ Hemophilia Yes ☐ No ☐ Parathyroid Disease Yes ☐ No ☐