RALPH M. FALUOTICO, JR., DDS
97 Monroe Road, Bath, NH 03740 • (603) 747-2037

DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. 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.

General: 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. 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.

Financial Agreement: The information below is to be read in its entirely by the patient and the individual named as the financially responsible party (if different than the patient) before signing below. We will be happy to answer any questions.

Payment Policy: Full payment is due at the time of service. We accept cash, checks, and credit cards. We do not have an in-house payment plan however, we offer Care Credit as a financial service, and would be happy to assist you with information regarding this option.

Interest: Interest at the rate of 1.5% per month will be charged on balances unpaid after 30 days.

Missed Appointments: Unless we receive notice of cancellation 48 hours in advance, you will be charged $75.00. Please help us service you better by keeping scheduled appointments.

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 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.

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: 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.

Minor Patients: Parents or guardians are responsible for all charges for minor children.

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

_____ _____

Person Financially Responsible Signature **Please PRINT Name**

(If different than below)

_____

Patient or Authorized Person's Signature: I authorize the release of any medical information necessary to process insurance claims and also certify that the above information is correct. I authorize payment of Insurance benefits to the providers of New Bridge Dental.

_____

Date (MM/DD/YYYY)

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Returned Checks:

Personal checks that are returned due to “insufficient funds” are subject to a $50.00 service fee.

Service Charge:

Payment is due at each appointment. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a $75.00 fee charged for missed or broken appointments without 48 hours notice. To avoid this charge, kindly give us a minimum of 48 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

Minors:

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to New Bridge Dental to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date: (mm/dd/yyyy)
_____	

Payment Method:

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance.

Payment Plans Available

Start treatment immediately and pay over time with low monthly payments.

CareCredit	**No-Interest Payment Plans** • Pay for treatment over 6 or 12 months with NO interest • As long as you pay the low minimum monthly payment each month when due, and the balance in full by the end of the promotional 6- or 12-month term, no interest will be charged on your purchase. **Low-Interest Payment Plans** • Enjoy low monthly payments with the 24, 36, 48, or 60 month extended plans. • The 14.9% APR is lower than average credit cards and makes convenient, fixed, and low minimum monthly payments possible. This option is available for treatment fees of $1000.00 or more. ($5000.00 or more for the 60 month plan.) If you choose this option, you can fill out a CareCredit application at our office.

Would you like to discuss our office's financial policy? ◯ Yes ◯ No

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New Patient Form

Date:

Patient Information

Title:	First Name:	Middle Name:	Last Name:

Sex:	Age:	Date of Birth (mm/dd/yyyy):	Marital Status:	Social Security #: - -

Home Phone: - -	Work Phone: - -	Cell Phone: - -	Email Address:

Home Address:	City:	State:	Zip Code:

Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	Zip Code:

Best Places and times to contact you:	Send appointment reminders via: ☐ Text Message ☐ Email

Please tell us where you heard about us:

☐ Friend or Relative (name):_____ ☐ Newspaper Ad ☐ Radio Ad
☐ Ad in Mail ☐ Saw our Office ☐ Insurance Company ☐ Our Website
☐ Search Engine (Google, etc.) ☐ Other Website: _____
☐ Other:_____

Was our website a factor in your decision to visit our practice? ◯ Yes ◯ No

Responsible Party (If someone other than the patient)

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #: - -	Holder of Dental Insurance for Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -

Insurance Information

Primary Insurance

First Name of Insured:	Middle Name:	Last Name:	Is insured a patient? ◯ Yes ◯ No

Insured's Birth Date:	ID #:	Group #:

Insured's Address:	City:	State:	Zip Code:

Insured's Employer Name:	Employer's Phone: - -

Employer Address:	City:	State:	Zip Code:

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Address

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Secondary Insurance				
First Name of Insured:	Middle Name:	Last Name:	Is insured a patient? ◯ Yes ◯ No	
Insured's Birth Date:	ID #:	Group #:		
Insured's Address:	City:	State:	Zip Code:	
Insured's Employer Name:	Employer's Phone: - -			
Employer Address:	City:	State:	Zip Code:	
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____				
Insurance Plan Name & Address				

Emergency Contact #1				
Title:	First Name:	Last Name:	Relationship to Patient:	
Home Phone: - -	Work Phone: - -	Cell Phone: - -	Email Address:	
Emergency Contact Address:	City:	State:	Zip Code:	

Emergency Contact #2				
Title:	First Name:	Last Name:	Relationship to Patient:	
Home Phone: - -	Work Phone: - -	Cell Phone: - -	Email Address:	
Emergency Contact Address:	City:	State:	Zip Code:	

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New Patient Form

Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ◯Yes ◯No

Do you smoke or chew tobacco? ◯Yes ◯No

Have you been treated in a hospital in the last five years? ◯Yes ◯No

If female, please mark if you are:

☐ Pregnant - If so, please enter your due date or week #:

☐ Trying to get pregnant ☐ Nursing ☐ On birth control

Please list all current prescriptions and supplements:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

How is your general health? ◯Good ◯Fair ◯Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Phone: - -

Do we have permission to contact your doctor regarding your care? ◯Yes ◯No

Date of your last dental visit:	Reason for this visit:

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Anemia	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
☐ Anticoagulants	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Arthritis	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Artificial Joints	☐ Hay Fever	☐ Pregnancy Due Date: _____	☐ Venereal Disease
☐ Asthma	☐ Head Injuries	☐ Radiation Treatment	☐ Codeine Allergy
☐ Blood Disease	☐ Heart Disease	☐ Respiratory Problems	☐ Penicillin Allergy
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever	OTHER:
☐ Cortisone	☐ Hepatitis	☐ Rheumatism	☐ _____
☐ Diabetes	☐ High Blood Pressure	☐ Sinus Problems	☐ _____
☐ Dizziness	☐ Jaundice	☐ Stomach Problems	
☐ Epilepsy	☐ Kidney Disease		

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign): _____	Date: (mm/dd/yyyy)

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HIPPA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.
Date: _____ Patient Name: _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents, and any care takers who can have access to this patient's records): Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration for these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.
The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian relationship of Legal Representative / Guardian

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 9, 2015, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize New Bridge Dental to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and
disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date: (mm/dd/yyyy)
_____	

If signing on behalf of someone, explain your relationship to the patient: