Financial and Insurance Policy

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at time of service

There is a $35.00 processing charge for non-sufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 90 days, I agree to pay the full remaining balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office in accordance with its credit terms and policy.

PLEASE UNDERSTAND THAT IT IS YOUR RESPONSIBILITY TO CONFIRM CURRENT COVERAGE WITH YOUR INSURANCE AND NOTIFY THE FRONT DESK OF ANY CHANGES 48HRS BEFORE YOUR APPOINTMENT TIME.

_____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I would like to give the following persons access to personal health information. (ex: spouse or family)

Name: _____ Relation: _____

Name: _____ Relation: _____

Signature (patient/parent/guardian):_____Date: _____

KILEY A. SMITH, DDS
GENERAL DENTISTRY

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 24, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professions, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke your authorization at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only with your consent.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: When we are required by law, we may use or disclose your health information.

Abuse or Neglect: We may disclose your health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or your safety or the health or safety of others.

National Security: We may disclose to military authorities the health information to Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials access to health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to correctional institutions or law enforcement offices having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards, or letters.

Patients' Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .15 for each page, $5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of our health information for a fee. Contact us using the format listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities for the last 6 years but not before April 14, 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please feel free to contact us. If you are concerned that we may have violated your privacy rights or if you disagree with a decision we made about access to your health information or if you want to have us communicate with you by alternative means or at an alternative location you may contact us at the information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Kiley A. Smith
1005 Marlandwood Road Ste # 104
Temple, TX 76502
Office: (254) 791-1010
Fax: (254) 791-1012
office@kileyasmithdds.com

KILEY A. SMITH, DDS
GENERAL DENTISTRY

1005 Marlandwood Rd Ste 104 Temple, TX 76502 (o): 254791-1010 (f): 254-791-1012

Acknowledgement of Receipt of Privacy Practices

You may refuse to sign this agreement

I have read/received a copy of this office's Notice of Privacy Practices

Print Patient Name_____

Patient/Guardian Signature_____

----------FOR OFFICE USE ONLY----------

We attempted to retain written acknowledgement receipt of our Notice of Privacy Practice, 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)

_____
_____
_____

Staff Member Signature_____ Date_____

Dental Patient Policies Form

Thank you for choosing Kiley A. Smith, DDS for your dental care. Our primary goal is to provide thorough dental care in a comfortable, relaxed environment. To ensure a long lasting and well-informed relationship we have listed our policies as they concern you. Please read through the following policy information and sign where indicated. Should you have any questions, please do not hesitate to ask one of our team members. Thank you.

Financial Policy

Insurance- If you have dental insurance, we will complete your insurance claim form and submit it to your insurance company as a courtesy to you. Although our office will call your insurance for a breakdown of benefits, PLEASE UNDERSTAND THAT IT IS YOUR RESPONSIBILITY TO CONFIRM AND MAINTAIN CURRENT COVERAGE WITH YOUR INSURANCE AND NOTIFY THE FRONT DESK OF ANY CHANGES 48 HRS BEFORE YOUR APPOINTMENT TIME. OUR OFFICE DOES NOT GUARANTEE PAYMENT OR COVERAGE BY YOUR INSURANCE POLICY. IN THE EVENT THAT YOUR INSURANCE DOES NOT COVER A PROCEDURE, PATIENT BECOMES FULLY FINANACIALLY RESPONSIBLE FOR TREATMENT COMPLETED.

Payments- Upon completion of your dental appointment, the front desk staff will produce an invoice outlining the estimated costs. You will be expected to pay for the services provided at the time services were rendered.

Forms of payment- Cash, Check, VISA, Master Card, Discover, American Express, Debit and Care Credit

NSF Checks- If we receive a check returned to us for insufficient funds, the following would occur: 1. A $20.00 charge will be applied to your account. 2. You must clear the account promptly by paying with cash, certified check, money order or credit/debit card. 3. Your privilege to write checks in our office may be jeopardized.

Collections- Should it be necessary to turn your account over for collection, you will be held responsible for any additional collection or attorney fees.

Scheduling Policy

Rescheduling or Canceling Appointments- The office requires that you inform us if you need to reschedule or cancel at least 48 hrs prior to that appointment. We accept cancellations on the answering machine or email.

Appointment Confirmation- We will attempt to reach you by using our automated reminder system, reminder card, email, text message or telephone prior to your appointment. We ask that you please reply in some form to let us know you will be making your scheduled appointment. If we have not received confirmation 24 hrs prior to your appointment time, we reserve the right to give your treatment time to another patient.

Missed and Late Appointments- You appointment time has been reserved especially for you at exclusion of others who may be waiting for an appointment. If you miss your appointment and we do not receive at least 48 hrs prior notice there will be Cancellation or No Show fee with a minimum $50 charge for a prophy appointment and a $75 an hr for a treatment appointment which includes SRP (Deep Cleaning), Fillings, Crowns, etc. If you arrive late, we may not be able to see you for that appointment.

I HAVE READ AND AGREE TO ALL POLICIES ABOVE

_____

_____

Print Name Date

_____

Patient/Guardian Signature

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____Today's Date_____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Do you take, or have you taken, bisphosphonates? Yes No

Do you use nicotine? Yes No

Are you taking any medications, pills, or drugs? Yes No If yes, please list: _____

_____

_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Please circle if you have or have ever had any of the following

AIDS/HIV Positive	Diabetes	Hypoglycemia	Rheumatism
Alzheimer's Disease	Drug Addiction	Irregular Heartbeat	Scarlet Fever
Anemia/Blood Disorder	Emphysema	Kidney Problems	Shingles
Angina	Epilepsy or Seizures	Leukemia	Sickle Cell Disease
Arthritis/Gout	Excessive Bleeding	Liver Disease	Sinus Trouble
Artificial Heart Valve	Fainting Spells/Dizziness	Low Blood Pressure	Stomach/Intestinal Disease
Artificial Joint	Frequent Headaches	Lung Disease	Stroke
Asthma	Heart Attack/Failure	Mitral Valve Prolapse	Swelling of Limbs
Breathing Problem	Heart Murmur	Osteoporosis	Thyroid Disease
Bruise Easily	Heart Pace Maker	Pain in Jaw Joint	Tonsillitis
Cancer	Heart Trouble/Disease	Parathyroid Disease	Tuberculosis
Chemotherapy	Hemophilia	Psychiatric Care	Tumors or Growths
Cold Sores/Fever Blisters	Hepatitis A, B, C	Radiation Treatments	Ulcers
Congenital Heart Disorder	High Blood Pressure	Renal Dialysis	Venereal Disease
Cortisone Medicine	High Cholesterol	Rheumatic Fever	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. 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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

KILEY A. SMITH, DDS
GENERAL DENTISTRY

Getting To Know You As Our Patient

How did you hear about our office?

O OUR WEBSITE O FRIEND/FAMILY_____ O GOOGLE SEARCH

ODENTIST_____ O OTHER:_____

Patient Name: (First)	(MI)	(Last)		Preferred Name:
Address:		City:	Zip:	Cell Phone:
Birthdate:	Social Security No.			Driver's License No.
Email:	Sex (Circle One): Male Female			Marital Status (circle one): Single Married Divorced

Previous Dentist:_____

Insurance: □ I have primary insurance. □ I have secondary insurance.

Responsible Party (if different from above):

Name:	Birthdate:	Social Security No.
Driver's License No.	Relation to Patient:	
Address:		

Emergency Contact Name:_____Phone:_____

I hear by authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. I consent to the use of these by the doctor for scientific papers or demonstrations. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications.

I understand if I miss or cancel an appointment with less than 48 hour notice, there will be a failed appointment fee of $25 per hour scheduled, which I agree to pay before any further appointments can be made.

_____ _____

Patient/Parent/Responsible Party Date

(I have read and agree to the content, terms, and conditions listed above)