**PATIENT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent's Name (if child): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (M.I.) (Last)

Address: City: State: Zip:

Home Phone: Work Phone:

 **- May we call on this phone:  Yes  No - May we call on this phone:  Yes  No**

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Texts Allowed Y\_\_\_ N\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **- May we call on this phone:  Yes  No May we contact you with this address? \_\_\_\_yes \_\_\_\_no**

Birth Date: Sex (M/F): \_\_\_\_\_\_\_\_\_\_\_\_\_ Social Sec. #:

Place of Employment:

Work Address:

Marital Status: Spouse's Name:

Referred by: Reason for Today's Visit:

Person to contact in case of emergency: Phone:

**DENTAL INSURANCE INFORMATION**

***As a courtesy to you, we do our best to facilitate your insurance claims. However, we are not agents of your insurance company. Your insurance benefits are a contract between you and your insurance company.***

Name of insured: Relationship to patient:

Insured's Social Sec. #: Insured's Birth date:

Insured's employer: Insurance company phone:

Insurance company: Group #:

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance address: City: State: Zip:

Do you have a secondary dental insurance?  NO YES If YES, complete the following:

Name of insured: Relationship to patient:

Insured's Social Sec. #: Insured's Birth date:

Insured's employer: Insurance company phone:

Insurance company: Group #:

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance address: City: State: Zip:

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_

General Health Assessment: Excellent Good Fair Poor

Are you under current medical treatment? Yes No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had **joint replacement surgery/artificial heart valve replaced**

or been told that you need to **premedicate** with an antibiotic before a dental visit? Yes No

1. Are you currently taking any blood thinners? Yes No
2. Have you ever received medications for osteoporosis? Yes No
3. Do you have any allergies or adverse reaction to drugs? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you smoke? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No
2. Do you drink alcohol? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No
3. Do you use recreational drugs/ marijuana? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No
4. How physically active are you? Extremely Active Active Not Active
5. Quality of sleep ranking (1-10): \_\_\_\_\_\_\_\_ Date of most recent set of dental x-rays: \_\_\_\_\_\_\_\_\_
6. How would you rate the condition of your mouth? Excellent Good Fair Poor
7. Previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Reason for leaving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. How often have you routinely seen your dentist? (please circle below)

Every 3 months Every 4 months Every 6 months Every 12 months Not routinely

1. What is your chief dental concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you currently taking any medication? Yes No

**Please list below:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Reason** | **Medication** | **Dosage** | **Reason** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Women Only: (please circle)**  Pregnant Nursing Receiving Hormone Replacement Birth Control

**Please circle if any history of the following:**

Artificial Joints Blood Disorder Fainting Spells Headaches

Acid Reflux/ Heart Burn Caffeine Dependency Fibromyalgia Sleep Apnea

Dementia/Memory Loss Thyroid Disorder Head Injuries Cancer

High Cholesterol Cardiac Problems Kidney Disease Epilepsy

Artificial Heart Valve Sinus Problems Latex Sensitivity Stroke

Intestinal Disorders Drug Dependency Hepatitis A B C HIV / AIDS

Bacterial Endocarditis Mental Health Issues Major Surgeries Pacemaker

Asthma / COPD Organ Transplant Anemia Emphysema

**(Please circle Y for yes and N for No below)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Toothaches | **Y** | **N** | Mouth Breather | **Y** | **N** | Jaw Joint Pain | **Y** | **N** |
| Bleeding Gums | **Y** | **N** | Snoring | **Y** | **N** | Popping / Clicking | **Y** | **N** |
| Uncomfortable Bite | **Y** | **N** | Grinding Teeth | **Y** | **N** | Limited Opening | **Y** | **N** |
| Tobacco/ Toxins | **Y** | **N** | Daytime Sleepiness | **Y** | **N** | Sore Muscles | **Y** | **N** |
| Hypertension | **Y** | **N** | Poor Sleep Quality | **Y** | **N** | Nerve Pain | **Y** | **N** |
| Clenching Teeth | **Y** | **N** | Nasal Congestion | **Y** | **N** | Oral Sores | **Y** | **N** |
| Forward Head Posture | **Y** | **N** | Tongue Tie | **Y** | **N** | Worn Teeth | **Y** | **N** |
| Gastric Reflux | **Y** | **N** | Chronic Cough | **Y** | **N** | Tongue Thrust | **Y** | **N** |
| Physical Inactivity | **Y** | **N** | Deviated Septum | **Y** | **N** | Crooked Teeth | **Y** | **N** |
| Pro-Inflammatory Diet | **Y** | **N** | Diabetes | **Y** | **N** | Chronic Pain | **Y** | **N** |

**Personal History** (please circle Yes or No)

1. Are you nervous about coming to the dentist? Yes No
2. Have you ever experienced an adverse reaction to local anesthetic? Yes No
3. Any history of braces or other orthodontic treatment? Yes No
4. Have you ever had a tooth removed? Yes No
5. Do you have any dental implants? Yes No
6. Do you wear complete or partial dentures? Yes No
7. Do you experience tension headaches, tired muscles, sore teeth? Yes No
8. Any history of trauma to your jaw and/or jaw joints? Yes No
9. Are your teeth crowding or developing spaces? Yes No
10. Do you experience dry mouth? Yes No
11. Do you wear a night time bite appliance? Yes No
12. Have you had your bite adjusted or balanced? Yes No
13. Do you regularly consume soda, juice, sports drinks, candy, or gum? Yes No
14. Have your teeth become shorter or thinner in the last 5 years? Yes No
15. Are any of your teeth sensitive to hot, cold, biting, or sweets? Yes No
16. Have you ever had a toothache or broken a tooth or filling? Yes No
17. Do you avoid brushing any part of your mouth due to discomfort? Yes No
18. Have you ever been diagnosed or treated for periodontal (gum) disease? Yes No
19. Are your teeth becoming loose? Yes No
20. Are you taking any multivitamin / dietary supplements? Yes No
21. Are you happy and confident with the appearance of your smile? Yes No

If not, what are your concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Consent**

By signing here, I consent to dental/ surgical procedures agreed upon. I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing you of any changes to my health history at my next appointment. I consent to our use and disclosure of protected health information to carry out treatment, payment, and health care operations. I have received a copy of our Notice of Privacy Practices.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photograph Consent**

By signing here, I hereby consent to having photographs of my teeth taken and used as before and after pictures on our website.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy**

By signing here, I am acknowledging that the office policy for cancellations or rescheduling requires a 48-business hour notice to avoid a broken appointment fee of $75 per hour for the hygienist and $150 per hour for the doctor. Longer appointments in our office may require a chair deposit that is non-refundable if cancelled.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dr. Natasha Radosavljevic reserves the right to communicate Private Health Information (PHI) with family

or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends,

please list those individuals that we are authorized to release information to.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I also give Dr. Natasha Radosavljevic and her staff permission to leave messages regarding my

appointments on my home, work, cell phone or email.

It is completely your decision whether or not to sign this authorization form. We cannot refuse

 to treat you if you choose not to sign this authorization.

If you do sign this authorization, you can revoke it later. The only exception is if we have already

acted in reliance upon authorization. If you choose to revoke your authorization, send us a written

note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often

has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the

information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source of Authority\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 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 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 Notice available upon request.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We may 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. An example of this would be coordinating treatment with a specialist.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you. An example of this would be sending a claim to your insurance company for payment.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Examples of this would include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, 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. If you give us an authorization, you may revoke it in writing 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 a 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 your healthcare or with payment to your healthcare, but only if you agree that we may do so.

**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 judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also 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.

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

**Required by Law**: We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect**: We may disclose your health information to appropriate authorities, if we reasonably believe that you are a possible victim of abuse, neglect or 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 safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official 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).

**PATIENT 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 must 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 beginning 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 beginning of this Notice. If you request copies we may charge you $1.00 for each page, $15.00 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 may 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 your health information for a fee. )

**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.

**Restriction:** You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment**: 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 of have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the beginning of this Notice. You also may 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 with the U.S. Department of Health and Human Services upon request.

We support your rights 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.

**Natasa Radosavljevic, D.D.S.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*\* You May Refuse to Sign This Acknowledgement \*\*

I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices. I have been provided the opportunity to ask questions about the notice, and my questions have been answered to my satisfaction.

(Please Print Name)

(Signature)

(Date)

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

 Personal Representative's Name: \_

Relationship to Patient:

**FOR OFFICE 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) \_

Notice Effective Date: April 2010

**FINANCIAL POLICY**

**We are committed to providing you with the best possible dental care.**

We also want you to be aware of our financial policy.

Payment is due at the time of treatment unless payment arrangements have been made. We accept cash, checks, Visa, MasterCard, American Express, Discover and CareCredit.

*Returned checks will result in a $30.00 charge to your account.*

Your appointment time is reserved exclusively for you.

**We require 48 BUSINESS hours of notice to avoid a broken appointment fee of $75.00 per hour for the hygienist and $150.00 per hour for the doctor. Longer appointments in our office may require a chair deposit that is non-refundable if cancelled.**

Account balances over 60 days will incur an 18% APR finance charge. Accounts greater than 90 days will be forwarded to an outside collection agency unless financial arrangements have been made.

***Dental Insurance***

For our patients who have dental benefits, our relationship is with **you**, not your insurance company.

We do our best to facilitate your dental claims. However, we are not agents of your insurance

company. **Your insurance benefits are a contract between you and your insurance company.**

***We are not a party to that contract.***

You are responsible to give us your correct insurance information. If you change your insurance,

you are responsible to give us the new information. If you do not inform us of any change, and do

not give us a copy of your current insurance card, you accept full financial responsibility for all charges.

If we are able to verify your insurance coverage, eligibility and benefits, we will bill your primary

insurance company and accept assignment. Any deductible(s), co-pay(s) and/or coinsurance(s)

are your responsibility and are due at the time of treatment unless payment arrangements have

been made.

Note that our office only files for the primary insurance policy. Any secondary insurance claim filings

are the responsibility of the insured. We do not accept assignments for secondary dental benefits.

The secondary insurance company will directly reimburse the insured, as our office will already be paid.

**We will file your dental claim and will make every attempt to collect from your insurance**

**provider. If all collection means have been exhausted on accounts greater than 60 days,**

**you will be responsible for payment.** **Once your insurance has paid, if you have a remaining**

**balance, you will be responsible for payment.**

I understand that I am responsible for my account and will assist in any means to collect from my

insurance provider. I authorize my insurance company to pay directly to Natasa Radosavljevic, D.D.S.

any dental benefits to which I am entitled. I also authorize the release of identifiable personal

information and medical records to my insurance company (ies) or designated representative.

I have read and understand the above policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature) (Date)

**THE THREE COMMITMENTS:**

A commitment between two people builds trust. I have three important commitments

in my practice. I have put them in writing because I live by them as does my team. I

realize that the institution of these three commitments may be different from what you

have been accustomed to in other dental practices; however, I believe that these three

commitments are necessary in building the trust that it takes for you and I to successfully

work together.

**Commitment to Treatment:**

Dental disease is nearly 100 % preventable. Therefore, I believe that all treatment begun

should be completed. I will deliver the best dental care that I am capable of delivering;

and, in return, I ask that you care for your dental health on a daily basis. Incomplete

treatment leads to unnecessary problems and complications, such as loss of teeth. It also

leads to more advanced disease which unnecessarily adds to your cost and can lead to a

breakdown in communication between the two of us. I know that you want as little dentistry

done in your lifetime as possible. Help yourself achieve that by following through with your

dental plan.

**Commitment to Appointments:**

I will reserve time for you. I will give you my utmost attention and care and will rarely keep

you waiting. An appointment scheduled in my office is a “bond of trust”. It, simply stated,

means that my team and I will be here to serve you and that you will be on time and prepared

 for your appointment.

**Commitment to Financial Considerations:**

I believe that I have a responsibility to use my best professional care, skill and judgment in

 helping you achieve your dental health goals. As I have stated above, I believe dental disease

 is nearly 100 % preventable. I will deliver the best dental care that I am capable of delivering

to help you attain your goals. My staff will do everything possible to maximize insurance

reimbursement (if applicable) and make your goals a financial reality, but remember, the

ultimate financial responsibility is yours.