Lake Country Dental

Ray D Snider DDS & Associates
General, Pediatric, Cosmetic, & Implant Dentistry

Dentistry for the Entire Family

Welcome to our Practice,

Our pediatric dental practice is dedicated to providing quality care in a setting that children of all ages can enjoy. We are committed to your child's individual needs, both emotional and therapeutic, so that we may provide the highest quality treatment. We accomplish this through efficient teamwork, compassion and patience.

Our staff of professionals are trained and experienced in pediatric dentistry, and we deliver the highest quality care with the very best materials available. You will find that your positive reinforcement and the atmosphere we have created here will give your child the best chance for a good first visit. In order for you to help us with this goal, we would like to offer your child encouragement such as, "The dentist is going to show you many new and fun things to make your teeth sparkle and make your smile bright." Expect your child to enjoy the first visit to our office and chances are he or she will do exactly that. Along with preparing your child, we must be thoroughly prepared for providing the best possible care for your child, so we ask that you please be candid in providing us with complete information concerning your child's dental, medical, and social traits.

We have sent the forms necessary to begin your child's dental records. Once this information is accurately filled out we will be able to effectively communicate with you about your child's dental needs. The forms included are: Patient health history and account information, our office financial policy, and an insurance form for those who have dental insurance. Once you have a chance to go over these forms, call our office if you have any questions.

We recommend an initial visit be scheduled for your child at age 12 months to be followed by enjoyable, familiarization visits which will lead up to a first comprehensive visit prior to age 3. The first visit for patients age 3 and above will consist of x-rays (if indicated), a complete oral and cavity examination to determine if any restorations are needed, and a complete cleaning and fluoride treatment by our hygienist. The hygienist and the dentist will complete the visit by having a consultation with you to relate all of their findings and answer any question you might have.

We hope you share in our belief that regular preventive dental health care is a sound investment in your child's health. We recommend an examination along with a cleaning and fluoride treatment every 6 months. This will be the backbone of preventive care for your child, and it will help us develop a strong, trusting relationship with both of you. We want you to be confident that we will effectively follow through with our best possible care of your child's dental development in order to achieve a healthy and attractive smile.

8461 Boat Club Road Fort Worth, TX 76179 (817) 236-8771 Phone (817) 236-8791 Fax
At Lake Country Estates on eagle Mountain Lake
www.lakecountrydental.com

Lake Country Dental

8461 Boat Club Rd.
Fort Worth, Texas 76179
817-236-8771 • Fax: 817-236-8249
www.smiledoc4kids.com

Name of Minor/Child______________________ Soc. Sec.: ____________________

Sex: F___ M ____ Age: _____ Birthdate:________________________

Home address:________________________Email:____________________

City:___________________State:________Zip:______________________

How did you hear about out office?

Phonebooks: AT&T _____ Family & Friends _____

Transwestern _____ Drive By _____

Yellowpages _____ Other _____

Person financially responsible:____

Home Phone:___________________ Alt. Phone:______________________

Work Phone:___________________ E-mail: _________________________

PARENT INFORMATION:

Father's Name: __________________ Mother's Name:____________________

Address:________________________ Address:__________________________

Home Phone:_____________________Home Phone:______________________

Employer:_______________________ Employer:_________________________

Soc. Sec.:_______________________Soc. Sec.:_________________________

Birthdate:_______________ Birthdate:__________________

INSURANCE INFORMATION:

Do you have dental insurance coverage for minor/child? Y N

Plan Name:________________Group Number:______________

Phone Number:____________ Policy Number:______________

Address:_______________________________________

DENTAL HISTORY:

Date of last dental visit:____________ For what service:____________________________

Has child complained about any dental problems?________________________________

How often does your child brush?______________ Floss?__________________________

Is fluoride taken in any form?____ Any injuries to mouth, teeth, or head? ____________

Any previous unhappy dental visits?____

Any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?

MEDICAL HISTORY:

Child's Physician:__________________City/State:____________Phone:______________

Date of last physical exam:____________________

Is minor or child:	Y	N	
Under care of physician	❑	❑	Medication:____________________________
Receiving any medication	❑	❑	______________________________________
Ever been hospitalized	❑	❑	Allergies:______________________________
Ever had surgery			______________________________________

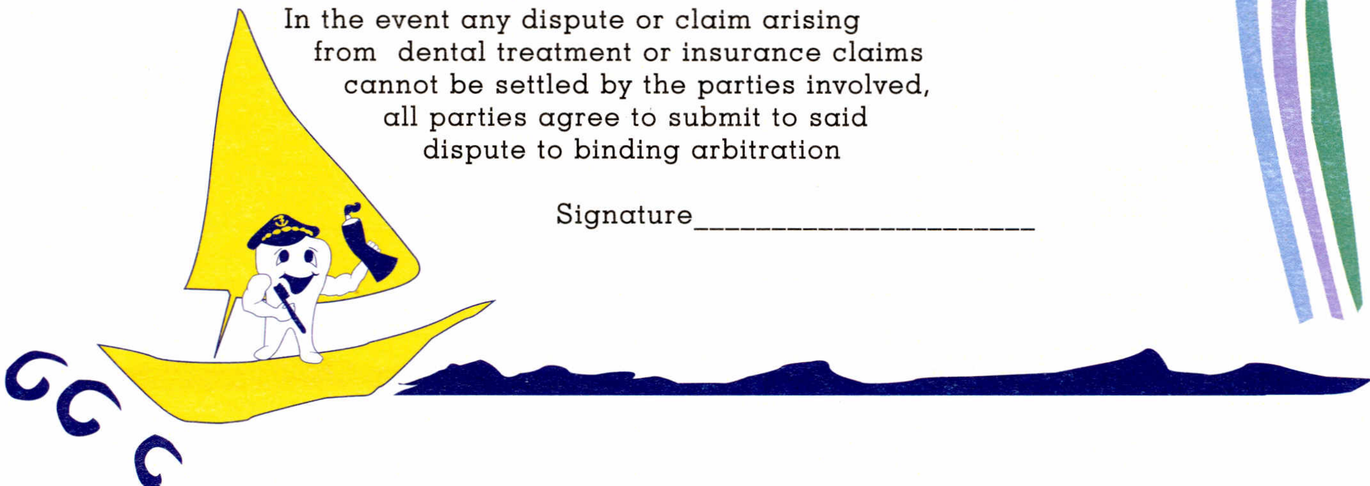
Has child had any history of or difficulty with any of the following? If YES, please check:

A.I.D.S.	❑	Cerebral Palsy	❑	Epilepsy	❑	Kidneys	❑	Rheumatic Fever	❑
Anemia	❑	Chicken Pox	❑	Fainting	❑	Liver	❑	Sinus Problems	❑
Asthma	❑	Convulsions	❑	Hearing	❑	Measles	❑	Thyroid Disease	❑
Bladder	❑	Diabetes	❑	Heart	❑	Mononucleosis	❑	Tuberculosis	❑
Cancer	❑	Drug/Alcohol	❑	Hepatitis	❑	Mumps	❑	Other	❑

In the event of an emergency, whom should we contact?

Name:________________________Relationship:______________Phone:_____________

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child.



In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by the parties involved, all parties agree to submit to said dispute to binding arbitration

Signature______________________

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

FINANCIAL POLICY

We appreciate you choosing Lake Country Dental for your family's dental care. At Lake Country Dental, we value our relationship with our patients and would like to offer the following as our payment policy:

If you have dental insurance, we will be happy to help you receive the maximum benefits available under your policy. However, please realize that the relationship is between you, the insured and your insurance company. If we do not receive payment from your insurance company within six weeks after submission of a claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed.

- A finance charge will be added to your account on any balance not paid by you or the insurance within six weeks from the date of service.
- Once the treatment plan and the estimated insurance benefits are reviewed with you, we require that you pay your portion in full at the time of service.
- For appointments that require the dentist to spend two or more hours with you during your appointment, a credit card will need to be provided to hold your appointment.
- For your convenience we accept cash, Visa, Master Card, Discover, American Express, and debit cards. We also offer Care Credit. Any Interest Free payment plans may include a financial planning fee.
- When impressions are taken for any restoration or appliance, the full fee is due when the appliance is ordered.
- Please note that the parent or guardian bringing the child into the office on the day of service will be expected to pay for services rendered. Only if payment arrangements have been made prior to appointment will we continue to see the child for treatment.

I have read and understand the payment policies for the office:

Patient's Name Printed: ____

Patient's Signature / Parent or Legal Guardian):

____

HIPAA RELEASE FORM

LAKE COUNTRY DENTAL & ASSOCIATES

I,_______________________________________, authorize the release of information of
(PRINT PATIENT / GUARDIAN NAME)

_______________________________________, including the diagnosis, records, examination and
(PATIENT NAME)
treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to (check one):

[ ] Spouse____

[ ] Child(ren)____

[ ] Other____

[ ] Information is not to be released to anyone. (Initial Here)_________

In further consideration for this, Lake Country Dental agrees to the same stipulations. This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other____

The best phone number to reach me at is:____________________________

Signed: _____________________________________ Date: ______/______/______

Witness:_____________________________________ Date: _____/______/_______

PARENTAL POLICY

At Lake Country Dental Pediatric & Associates we want you and your child to have the best dental experience possible. Pleasant visits to the dental office help a child establish trust and confidence that will last a lifetime. Lake Country Dental Pediatric & Associates have been specially trained to help young, apprehensive children feel good about seeing the dentist and taking care of their teeth. Friendly, compassionate professionals and bright, cheerful office surroundings are all there to help your child feel comfortable and at ease with visiting the dentist. We recommend scheduling younger children in the morning when they are most rested and cooperative. We have open working areas and your child is NEVER left unattended.

Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits negative behavior. This is normal and will soon diminish. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an open environment designed for children.

It is best if you refrain from using words around your child that might cause unnecessary fear, such as needle, pull, drill or hurt. The office makes a practice of using words that convey the same message, but are pleasant and non-frightening to the child. Please do not tell your child the "dentist will not hurt" as this may never have entered his/her mind. Instead, you may wish to assure your child that Lake Country Dental & Associates will be gentle, friendly and fun. *We are very happy that you chose to bring your child to our office and we will continue to make it a positive experience for everyone.*

Respectfully,
Lake Country Dental & Associates

Acknowledgment of Parental Policy

Signature____ Date______________________

Patient name____
(Please print)

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

No Show Policy

We understand schedules change and you may not be able to keep your appointment. If you are unable to keep your scheduled appointment, please call us 24 hours in advance. Failure to do so will result in a $35 cancellation fee per appointment. If you miss two appointments without proper notification we reserve the right to dismiss the patient from care.

_______________________________________ __________________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

(DENTAL)

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 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. This Act gives you, the patient, significant new rights to understand and control how your health 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 only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill 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.

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.

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 to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of ____________________, 20___ 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.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of 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.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

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

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

LAKE COUNTRY DENTAL & ASSOCIATES
8461 Boat Club Road
Fort Worth, TX 76179

I,____, hereby acknowledge that I have received and/or reviewed a
(Print Patient Name)
copy of **Lake Country Dental & Associates'** *HIPAA Notice of Privacy Practices*.

I understand that **Lake Country Dental & Associates** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Lake Country Dental & Associates'** revised *HIPAA Notice of Privacy Practices* upon request. I understand that, if I have questions about **Lake Country Dental & Associates'** *HIPAA Notice of Privacy Practices*, I may contact:

Lake Country Dental & Associates
Ray D. Snider, DDS
8461 Boat Club Road
Fort Worth, TX 76179
817.236.8771

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Lake Country Dental & Associates** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Lake Country Dental & Associates'** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Ray D. Snider, DDS noted above, for assistance.

____ ______________________________
Patient Signature Date

____ ______________________________
Signature of Parent/Guardian Print Name of Parent/Guardian

FOR OFFICE USE ONLY

Lake Country Dental & Associates made a good-faith effort to obtain Acknowledgement from the patient noted above, receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Lake Country Dental & Associates** was unable to obtain a signed Acknowledgement for the following reasons(s):

□ Refusal to sign Acknowledgement on __________________ (date)

□ Communication barriers prohibited us from obtaining a signed Acknowledgement

□ An emergency situation prohibited us from obtaining a signed Acknowledgement

□ Other (describe): ____