LAKE COUNTRY DENTAL
RAY D. SNIDER, D.D.S., and ASSOCIATES
Cosmetic, Family and Implant Dentistry

WELCOME TO OUR PRACTICE

Patient Information

Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: HM (_____)_____ WK (_____) _____ CELL (_____) _____

Birthdate: _____ Social Security #: _____ Age: _____

Driver License #: _____ State: _____ Please circle: Male / Female Married / Single / Divorced / Widowed

Responsible Party Information

Name: _____ Social Security #: _____

Address: _____ City/State/Zip: _____

Phone: HM (_____) _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Age: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

How would you like to pay for today's visit? Credit Card / Check / Cash / Monthly Payments with approved credit

Insurance Information

Primary Insurance Co.: _____ Phone: (_____)_____

Employer: _____ Group #: _____ Employee Name: _____

Birthdate: _____ S.S.#: _____ Employee #: _____

Secondary Insurance Co.: _____ Phone: (_____)_____

Employer: _____ Group #: _____ Employee Name: _____

Birthdate: _____ S.S.#: _____ Employee #: _____

Getting To Know You

Are other members of your family patients at our office? YES / NO

Name(s): _____ Relationship: _____

Name(s): _____ Relationship: _____

How did your hear about our office? _____

Person to contact for emergency: _____ Phone: (_____) _____

Address: _____

Dental Health History (Confidential)

Reason for today's visit?: _____

Why did you leave your former dentist? _____ Date of last x-rays: _____

Do you have problems with any of the following:

____ Mouth Odor	____ Grinding Teeth	____ Heat Sensitivity
____ Bleeding Gums	____ Loose Teeth or Broken Fillings	____ Sweet Sensitivity
____ Clicking or Popping Jaw	____ Peridontal Disease/Treatment	____ Sensitivity to Biting Pressure
____ Food Collection Between Teeth	____ Cold Sensitivity	____ Sores or Growths in Mouth

How often do you floss? _____ How often do you brush? _____

Medical History (Confidential)

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? YES/NO If yes describe: _____

_____

Have you ever had a blood transfusion? YES/NO If yes give approximate date(s): _____

(Women) Are you pregnant? YES/NO Nursing? YES/NO Taking Birth Control Pills? YES/NO

Check if you have or have had any of the following:

____ AIDS	____ Cortisone Treatments	____ Hepatitis Type _____	____ Rheumatic Fever
____ Anemia	____ Cough, Persistent	____ High Blood Pressure	____ Scarlet Fever
____ Arthritis, Rheumatism	____ Cough up Blood	____ HIV Positive	____ Shortness of Breath
____ Artificial Heart Valves	____ Diabetes	____ Jaw Pain	____ Skin Rash
____ Artificial Joints	____ Epilepsy	____ Kidney Disease	____ Stroke
____ Asthma	____ Fainting	____ Liver Disease	____ Swelling of Feet or Ankles
____ Back Problems	____ Glaucoma	____ Mitral Valve Prolapse	____ Thyroid Problems
____ Blood Disease	____ Headaches	____ Nervous Problems	____ Tobacco Habit
____ Cancer	____ Heart Murmur	____ Pacemaker	____ Tonsillitis
____ Chemical Dependency	____ Heart Problems _____	____ Psychiatric Care	____ Tuberculosis
____ Chemotherapy	_____	____ Radiation Treatment	____ Ulcer
____ Circulatory Problems	____ Hemophilia	____ Respiratory Disease	____ Venereal Disease

Do you need Antibiotic Premedication prior to dental treatment? YES / NO

List medications you are currently taking: _____

Allergies: ____ Aspirin ____ Penicillin ____ Codeine ____ Local Anesthetic Other: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information cab be dangerous to my health. I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by parties involves, all parties agree to submit said dispute to binding arbitration.

Date: _____ **Signature**: _____

Dr. Notes: _____

_____

FINANCIAL POLICY and INSURANCE GUIDELINES

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care your family deserves.

- If you have dental insurance, we will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you and your children achieve the best oral health possible. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination. Initial _____

- While we accept all dental insurance plans, we are considered in-network with most PPO dental plans. Delta Dental members: If you receive an insurance check it is to pay your claim at our office. Please bring it in ASAP. Being out of network does not mean you do not receive benefits. We strive to help you make optimal use of your dental insurance and as a courtesy to our patients, we are happy to file your dental insurance claims. Initial _____

- Your insurance policy is an agreement between you and your insurance company; we ask that all patients be directly responsible for all charges. Your estimated co-payment will be due at the time of service, however we cannot guarantee any estimated coverage. You will be expected to pay for services in full if this office is unable to verify your plan information before treatment. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. Initial_____

- If payment for services already rendered has not been paid in full within 6 weeks, either by you or your insurance company, the remaining balance for your treatment is considered due and must be collected from you. Office Delinquent balances over 90 days old will be transferred to a collection agency. The fee accessed for this transfer and administrative expenses is $30.00. Any fees incurred from the collection agency and attorney employed will be passed on to you. Further appointments will not be scheduled until all balances and fees are paid in full. Future appointments will be on a cash only basis. Initial _____

- We accept the following forms of payment: Cash, Check, American Express, Visa and MasterCard. In addition, we offer Care Credit, a patient payment program offering a full range of Deferred Interest and Extended Payment Plans for treatment. Initial _____

- Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office. Your check will be retained by our office until a full cash payment is received. Initial_____

- Separated or divorced parents of minors, who are responsible for one half of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. Initial _____

- We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have. Initial _____

I have read and agree to the Financial Policy and Insurance Guidelines.

Signature of Patient or Responsible Party: _____

Date:_____

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

Cancellation Policy

We regret patients must sometimes wait a lengthy time to be seen by one of our dentist. Due to the high demand of appointments and in order to be respectful of the dental needs of all of our patients please be courteous and call our office promptly if you are unable to attend an appointment.
We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment, we require 24 hours notice.

There will be a $35 charge for every appointment missed without proper notification (as mentioned above).

If you miss 2 appointments without proper notification we reserve the right to dismiss the patient from care.

_____ _____

Signature Date

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 Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.

- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. 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 certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- 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 request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- 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 January 1, 2003 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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact: For more information about HIPAA or to file a complaint:

Linda Snider
Dr. Ray D. Snider
8461 Boat Club Road.
Fort Worth, TX 76179
817-236-8771

The U.S Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

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): _____

Lake Country Dental
Ray D. Snider, DDS & Associates

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time

LAKE COUNTRY DENTAL

Patient Name_____

Due to confirmed Cases of COVID-19(CoronaVirus) within the United States, the CDC requires that healthcare facilities conduct a strict screening process on individuals with respiratory symptoms as well as those who have traveled outside of the United States.

Have you had any of the following?

Fever, Cough, Shortness of breath Yes No

Have you been in contact with anyone that has had these symptoms?

Yes No

Have you traveled outside of the country within the last 14 days or been in contact with someone who has?

Yes No

Have you been in contact with anyone who had recent exposure to CoronaVirus? Yes No

If you have answered yes to any of the boxes above we may ask you to reschedule your appointment to prevent the transmission of various diseases and for the safety of other patients and our staff.

Signature:_____ Date:_____

Phone #_____