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 Road
Fort Worth, Texas 76179
871-236-8771 • Fax: 817-236-8249
www.lakecountrydental.com

Name of Minor/Child ______________________ Soc. Sec.: ______________________

Sex: F____ M____ Age: ______ Birthday: ______________________

Home address: ______________________________________________

City:____________________ State: ________ Zip: ______________________

How Did you hear about our office?______________________________________

Phonebooks: AT & T ____ Family & Friends ____

Transwestern ____ Drive By ____

Yellow Pages ____ Other ____

If you are the parent bringing the child in for dental treatment, you are the

Responsible financial party.

Home Phone:________________________ Cell:____________________________

Work Phone:________________________ Email:___________________________

PATIENT INFORMATION

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

Address:_________________________ Address:_____________________________

Cell Phone:_______________________ Cell 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 floride 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 | ❑ | ❑ |
| Receiving any medication | ❑ | ❑ |
| Ever been hospitalized: | ❑ | ❑ |
| Ever had surgery | | |

Medication: __________

__________

Allergies: __________

__________

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

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A.I.D.S. | ❑ | Bladder | ❑ | Digestive Issues | ❑ | Hearing | ❑ | Mononucleosis | ❑ |
| ADD/ADHD | ❑ | Cancer | ❑ | Downs Syndrome | ❑ | Heart | ❑ | Mumps | ❑ |
| Anemia | ❑ | Cerebral Palsy | ❑ | Drug/Alcohol | ❑ | Hepatitis | ❑ | Rheumatic Fever | ❑ |
| Aspergers | ❑ | Chicken Pox | ❑ | Epilepsy | ❑ | Kidneys | ❑ | Sensory Issues | ❑ |
| Asthma | ❑ | Convulsions | ❑ | Fainting | ❑ | Liver | ❑ | Sinus Problems | ❑ |
| Autism | ❑ | Diabetes | ❑ | Gagging | ❑ | Measles | ❑ | Thyroid Disease | ❑ |
| Other | ❑ | | | | | | | Tuberculosis | ❑ |

Please List __________

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 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 said dispute to binding arbitration.**

Signature __________

# 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:___________________

# 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 Pediatrics 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 Pediatrics and 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.

**If your child is over the age of three, and/or having dental treatment other than a cleaning, we ask that you allow them to accompany our staff, by themselves, through the dental experience.** 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 Pediatrics & 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 delightful experience for everyone.*

Respectfully,
Lake Country Dental Pediatrics & Associates

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Acknowledgment of Parental Policy

Signature______________________ Date________________________________

Patient name_______________________
(Please print)

*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

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**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**

**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 #_________________________________