

NEW PATIENT REGISTRATION

Patient's Personal Information

First Name: _____ Last Name: _____ D.O.B.: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Ext.: _____
Sex: M F Single Married Divorced Separated Widowed So. Sec.#: _____
Employer: _____ Occupation: _____ How Long: _____
Address: _____ City: _____ State: _____ Zip: _____
Driver's License #: _____ State: _____ Exp. Date: _____

Financial Information

Person Responsible for Account: First Name: _____ Last Name: _____
Relationship to Patient: _____ D.O.B.: _____ Age: _____
Address (if different from patient): _____
Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Ext.: _____
Soc.Sec.#: _____ Employer: _____ Occupation: _____

Please Tell Us More About You

Is another member of your family or relative a patient in our office? Name: _____ Relationship: _____
Who may we thank for referring you to our office? Name: _____ or Source: _____
If married, what is your spouse's name? _____ Employer: _____ Work#: _____
Whom should we contact in case of emergency: Name: _____ Relationship: _____
Address: _____ Phone #: _____

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Dental Information and History

When was your last professional dental cleaning? _____

Have you had any x-rays within the past year? Y N Two years? Y N

What is the reason for your visit today? _____

If there were a quick and simple way to whiten your teeth, would you be interested? _____

If you could change anything about your smile, what would it be? _____

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostics aids deemed necessary. I consent to my photographs to be used to help educate future patients. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible risks.

I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

Patient's Signature

Date

Witness

Parent/Responsible Party's Signature

Relationship to Patient

Dr. Holly Nadji, DMD

www.gentleladydentist.com

APPOINTMENT AND FINANCIAL POLICY

In order to keep down treatment costs and provide the most optimal dental care possible we have established the following policies. We ask that you take a few minutes to read and sign below to acknowledge your acceptance of these policies. We appreciate your cooperation and thank you for allowing us to help maintain your dental health.

APPOINTMENTS

Our office requires a full 72-hour-notice (NOT INCLUDING WEEKENDS) to change an appointment, to avoid a broken appointment fee equal to \$25.00 per half hour of appointment time scheduled. We understand that unexpected emergencies can arise and ask to be notified as soon as possible so exceptions can be considered. By providing the required notice, this gives emergency patients who are in pain, or those waiting for sooner appointments an opportunity to be seen sooner.

PAYMENT ARRANGEMENTS

Payment is expected upon your arrival to the office, which you will know based on the estimate we gave you. Prior to each visit you will be presented with an estimate of your expected portion for your next visit. Payment is accepted in the form of cash, checks (except for first time patients), MasterCard, Visa, Discover, and Care Credit and Capital One. For your convenience we also provide affordable monthly payment plan options for larger procedures, which allows you to have any necessary or desirable treatment done now and pay for it over time. Please see one of the front office staff for more information about these options.

DENTAL INSURANCE

Please understand that your insurance is a contract between you, your employer and the insurance company. We are not a part of this contract. As a courtesy, Dr. Holly Nadji's staff will bill your insurance company. However, if we do not hear from them within 30 days of billing, the balance will become your responsibility and is to be paid in full. The responsibility will become yours to collect your reimbursement from your insurance company. "Usual and customary rates" means that an insurance company has a limit upon the amount it will pay on a procedure. Our fees reflect the quality of care our patients receive. Some insurance companies may pay on a much lower fee scale than others. The patient is responsible for any amount remaining after the insurance has paid its portion. We regret that we are unable to become involved in disputes between you and your insurance company regarding usual and customary rates, deductibles, or covered charges, other than to provide factual information.

FINANCIAL AGREEMENT and INSURANCE RELEASE

I have read and acknowledge and agree to the above policies. All information furnished by me is correct to the best of my knowledge. I authorize release of all pertinent information to my insurance company. I also authorize my insurance company to pay directly to Dr. Holly Nadji, the benefits to which I am otherwise entitled, if they have been assigned. I understand that when I undertake treatment in this office, I am responsible for all fees incurred and agree to pay for services rendered, regardless of my insurance benefits. I understand and agree that any information provided to me by this office regarding my insurance benefits is an "estimate" based on information received about my particular benefit contract, and not a guarantee of payment. I understand and agree to be responsible for payment of any balance remaining after Dr. Holly Nadji receives expected insurance benefits. I understand a \$40.00 fee assessed on all returned checks. I agree to be responsible for all attorneys' fees, court costs, and collection agency fees if my account is sent to an attorney for collection, or referred to a collection agency.

Patient's (Responsible Party) Signature: _____

Print Name: _____

Date: _____

Witness (Staff Member): _____

Dr. Holly Nadji, DMD

7807 Baymeadows Rd., East, #206
Jacksonville, FL 32256
Office: 904.731.1919 FAX: 904.996.0018
www.gentleladydentist.com

CANCELLATION/ NO SHOW POLICY

In order to be fair to our loyal patients who are waiting for sooner appointment times, as well as those patients who keep their scheduled appointments, any appointments broken or cancelled without the required 72-hour notice not including weekends or holidays will incur a fee of \$25.00 per-half-hour of scheduled time.

Initials (I understand 72-hour notice)

We understand that emergencies do sometimes occur and we ask to be notified as soon as possible if you are unable to make your appointment so we can help our other patients who are waiting for appointment times.

Patient/Parent Signature: _____

Date: _____

Witness/Staff: _____

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Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have read and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the items of it's Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

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”) 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 person 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.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- **Treatment:** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **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 Operation:** 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 also conduct fundraising for our benefit.

We may without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances.

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent, or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

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 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 Oct.14, 2002 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 a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the 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, Offices of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll-Free: (877) 696-6775
(202) 619-0257