Your Perfect Smile Cosmetic & Family Dentistry
1939 Lawrence Road Kemah, Texas 77565
(281) 538-9300 Phone (281) 538-9031 Fax

Patient Name: _____
Date:_____

HIPAA POLICY
I acknowledge that I understand Your Perfect Smile Cosmetic & Family Dentistry's Notice of Privacy Practices and HIPPA policies. (Forms available on request)

Signature _____ Date _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date __/__/____ added / removed
2. _____ Relationship: _____ Date __/__/____ added / removed
3. _____ Relationship: _____ Date __/__/____ added / removed
4. _____ Relationship: _____ Date __/__/____ added / removed

IN CASE OF EMERGENCY
In the event of an emergency, please list who should be notified:

Name: _____

Phone Number: _____

CONSENT TO DIGITAL PHOTOGRAPHY
As part of your new patient appointment, we will perform routine diagnostic procedures, such as X-rays and photographs. In connection with dental services, which I am receiving from Stacie L. Holt, DDS/Tracie L. DeVault, DDS, I agree and consent to allow photographs taken before, during, and after completion of my dental treatments to be used for dental records, patient counseling, or other purposes.

Patient Signature: _____ Date: _____

PATIENT GUIDELINES

Please read the information listed below carefully. This form is designed to assist you, our patient, in understanding our guidelines and to provide you with helpful information regarding your responsibilities.

HOURS OF OPERATION:
Drs Holt and DeVault patient hours: by appointment

PATIENT CARE:
Our goal is for you to make informed decisions regarding your care. We will thoroughly diagnose your dental needs and assist you in your decisions regarding treatment. You will receive a written copy of proposed treatment.

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INSURANCE:
As a courtesy to our patients, Your Perfect Smile Dentistry will file dental claims on your behalf to your insurance company. Although we are not currently "in network" with any dental benefit plans, we will accept payment from your insurance company. Any amounts not paid by insurance are the responsibility of the patient/account holder. **Dental benefit plans are a contract between the employer/employee and the insurance company , we are unable to guarantee the outcome of your claim and payment.** It is best for you to contact your insurance company directly for details regarding your benefits 48 hours prior to your appointment. **Please note, the design of your dental benefit plan may limit your reimbursement.**

Patient Signature_____ Date: _____

PAYMENT OPTIONS:
After establishing yourself as a "patient of record" all patient portions are due at the time of service. We realize that every person's financial situation is unique and different. It is for this reason that we offer a wide variety of flexible payment arrangements. Our goal is for you to retain a healthy and confident smile. We accept payments by cash, check, credit card or our special partnership payment plan through CareCredit. We agree to track your insurance claim for 30 days. At that time, any unpaid amounts will be transferred to the credit/debit card (Mastercard/Visa/Amex/Discover/CareCredit) of your choice. You will receive a courtesy call first to notify you that your payment is going to be posted. Please provide the information below:

Credit/Debit/CareCredit Card #: _____ Exp. Date: _____
Signature: _____ Date: _____

I _____, authorize Your Perfect Smile Dentistry, to charge my unpaid balance to the account listed above. I understand that I will be provided with a statement of all charges posted to this account. After that time, any payments received from your insurance company will be refunded directly to you or credited to your account for future treatment.

CANCELED/RESCHEDULED/MISSED APPOINTMENT:
We realize our patients have very busy schedules. We work very hard to keep your wait time to a minimum and to find appointment times convenient for you and your family. In a continued effort to accommodate the schedules of our growing patient numbers**, we require a 48 hour notice to cancel or reschedule appointments.** This allows us to offer that time to a patient who is waiting for an appointment. A missed appointment fee 50% of the value of the scheduled appointment and/or dismissal from the practice may apply.

PATIENT INFORMATION:
Please keep us informed of any changes in your contact information, address, dental benefits information and any issues that may affect who may have access to your health information.
I understand that payment is due when services are rendered.

Signature: _____ Date: _____

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