deepriver
family & cosmetic dentistry
C. Cassidy Bray, DDS

Financial Policies

Thank you for choosing Deep River Family and Cosmetic Dentistry. We are committed to providing you with the highest quality of dental care and will do everything we can to help you maintain a healthy smile. Your trust is important to us, and we want to make sure you understand your financial responsibilities and options before we begin treatment.

Insurance

As a courtesy to you, we will file your claim to your insurance company. However, your insurance policy is a contract between you and your insurance company. We can make no guarantees regarding the accuracy of the insurance estimate, and you will be responsible for any balance not covered by your insurance plan.

Payments

All fees and payments are due at the time of service. If you have insurance, your co-payments, plan deductibles or portion will be due at the time of service. You may use Cash, Check, Visa, MasterCard, Discover, American Express or CareCredit.

Treatment Fees

We are confident that our fees reflect the overall quality of care and services that we provide. We work hard to keep treatment fees low and reasonable and for that reason, these fees are not negotiable. In the case of extenuating circumstances, any discount will be at the discretion of Dr. Bray.

Cancellation and Re-Scheduling

We understand that life can be unpredictable at times, however, please understand that your appointment time is reserved especially for you. If you wish to cancel or re-schedule your dental appointment, please call our office during regular office hours at your earliest convenience. Our office does request a minimum of two business days to avoid a cancellation fee. The fee for not appearing or canceling the same day of your appointment will be determined based on the amount of time that was reserved for you and the number of occurrences. Our regular office hours are Tuesday-Friday, 8:00 am to 5:00 pm Closed from 1-2pm for lunch.

I have read and agree to the policies stated above:

Print Name: _____

Sign: _____

Date: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The Notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing the consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to out use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The practice reserves the right to change the privacy policy as allowed by law.
3. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and full disclosure will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we phone, Email, or Send a text to you to confirm appointment? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the Members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date:_____

Witness: _____ Date: _____

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CONFIDENTIAL INFORMATION QUETIONNAIRE

Patient's Legal Name _____

(Last) (First) (MI)

Date of Birth _____ Sex _____ SSN _____

Prefer to be called_____

Patient's Address_____ Street_____ APT#_____

City_____ State _____ Zip_____

Email_____ Home# _____ Cell# _____

Marital Status (Circle One) S M W D Under Age 18

Patient's/ Guardian's Employer _____

Occupation_____ Work# _____

Work Address_____

Spouse's Name_____

Spouse's Employer _____

Occupation_____ Work# _____

Other family members that are patient's here_____

Who can we thank for referring you to our office? _____

EMERGENCY CONTRACT INFORMATION

Name _____ Relationship _____

Home# _____ Work#_____ Cell#_____

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MY DO THE FOLLOWING WITH MY PERMISSION:

Contacted me at home Y or N Contacted me via cell phone Y or N Contacted me at work Y or N

Contact me via Email Y or N Leave messages on my Home Answering machine Y or N

Leave messages on my Cell Voicemail Y or N Leave messages on my work Voicemail Y or N

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INSURANCE AND FINANCIAL INFORMATION

Insurance Company Name_____

Insurance Address _____Phone #_____

Subscriber's Name_____ DOB_____ SSN _____

Patent's relationship to subscriber (Circle one) Self Spouse Dependent

Group/ program Number _____ Employer_____

Employer's Address _____

SECONDARY INSURANCE

Insurance Company Name_____

Insurance Address _____Phone #_____

Subscriber's Name_____ DOB_____ SSN _____

Patent's relationship to subscriber (Circle one) Self Spouse Dependent

Group/ program Number _____ Employer_____

Employer's Address _____

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

Healthcare Providers Y or N Insurance Companies Y or N

Others_____

_____

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL? NO, it is unnecessary YES, it is helpful reminder

Signature_____ Date_____

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MEDICAL HISTORY

Patient Name_____ Nickname_____ Age_____

Name of Physician/ and their specialty _____

Most recent physical examination_____ Purpose_____

What is your estimate of your general health? (Circle One) Excellent Good Fair Poor

List all medications, supplements, and or vitamins taken within the last two years _____

_____

_____

Describe any current medical treatment, impending surgery, genetic/ development delay, or other treatment that may possible affect your dental treatment. (Botox, Collagen injections) _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD: (Circle One) Y or N

1. Hospitalization for illness or injury **Y N**
2. An allergic reaction to **Y N**
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver,_____)
   - latex
   - Other_____
3. Heart problems, or cardiac stent within the last 6 months **Y N**
4. History of infective endocarditic **Y N**
5. Artificial heart valve, repaired heart defect (PFO) **Y N**
6. Pacemaker or implantable defibrillator **Y N**
7. Orthopedic implant (joint replacement) **Y N**
8. High or low blood pressure **Y N**
9. A stroke (taking blood thinners) **Y N**
10. Anemia or other blood disorder **Y N**
11. Prolonged bleeding due to slight cut **Y N**
12. Emphysema, Shortness of breath, Sarcoidosis **Y N**
13. Tuberculosis, Measles, Chicken pox **Y N**
14. Asthma **Y N**
15. Breathing or sleep problems **Y N**
16. Kidney disease **Y N**
17. Liver disease **Y N**
18. Thyroid, Parathyroid disease, or calcium **Y N**
19. Hormone deficiency **Y N**
20. High cholesterol or taking statin drugs **Y N**
21. Diabetes(hbAc1)_____ **Y N**
22. Stomach or duodenal ulcer **Y N**
23. Digestive Disorders _____ **Y N**
24. Osteoporosis/ Osteopenia **Y N**
25. Arthritis **Y N**
26. Autoimmune Disease **Y N**
    (rheumatoid arthritis, lupus, scleroderma)
27. Glaucoma **Y N**
28. Head or Neck Injuries _____ **Y N**
29. Epilepsy, Convulsions (seizures) **Y N**
30. Neurologic Disorders _____ **Y N**
    (ADD/ADHD, Prion disease
31. Viral Infections and cold sores **Y N**
32. STI/STD/HPV _____ **Y N**
33. Hepatitis (type)_____ **Y N**
34. HIV/ AIDS _____ **Y N**
35. Tumor, Abnormal growth **Y N**
36. Radiation therapy _____ **Y N**
37. Chemotherapy, Immunosuppressive medication **Y N**
38. Psychiatric Treatment **Y N**
39. Taking Medication for weight management **Y N**
40. A smoker, smoked previously or use smokeless tobacco **Y N**
41. Currently Pregnant **Y N**

Patient's Signature _____

Date _____