Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive the maximum benefits under the policy. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment is due when services are rendered unless other arrangements are made. We accept cash, checks, MasterCard/Visa, American Express, and Discover Card. There will be a charge for each returned check or declined credit card or electronic payment. Treatment involving laboratory work, such as dentures and crowns, requires half the fee when we start and the balance at delivery. A charge will be made for broken appointments cancelled without 24 hours notice. If you indicate that someone else is responsible for the cost of your treatment, please remember that ultimately you are responsible for any unpaid balance.

In most cases we will accept assignment of insurance benefits. Medicare is an exception. Your doctor has opted out of Medicare, which provides extremely limited dental benefits. Neither we nor any Medicare beneficiary may bill for or receive payment for services rendered in our office. Other dental benefit plans vary in the amount of coverage they provide, with some covering a high percentage and a wide range of treatment, while others cover lower percentages and fewer procedures. Keep in mind that many pay according to a fee schedule, which might have no relationship to the fees in this area. Remember that the insurance contract is between you (or your employer) and the insurance company; we are not a party to that contract and the responsibility is between you and our office. When we accept assignment of benefits, we are not agreeing to a reduced fee, we are simply allowing that portion of the fee your insurance covers to be paid directly to us by your insurance company. We will estimate your share, including any deductible, based on our experience with your policy, and this amount is due at the time of service. If we do not receive the insurance payment within 60 days, the full balance will be due and payable by you. Any balance over 60 days will incur financial charges at a rate of 1.5% per month with a minimum finance charge of $1.00. Past due accounts may be placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for a partial payment made on the past due account.

The type of treatment we recommend is based on our professional judgment, not on what your dental benefits cover. We do not believe that it is in your best interest to compromise your treatment in order to accommodate your insurance benefits, which might be less than optimal. Dental benefits are not designed to delineate your treatment needs, but rather to assist you in the cost of treatment. We understand that insurance coverage might play a part in your treatment decisions, but we will recommend what is best for you regardless of insurance coverage. We are happy to discuss the treatment plan with you, thus involving you, rather than your insurance company, in the decision. For patients wishing to make extended payments, we offer a third–party financial option. Alternatively, we will in some cases agree to bill your credit card a set monthly amount. We cannot, however, offer credit to persons unable or unwilling to meet the above options. When granting any credit, we may, at your option, run a credit report in accordance with applicable laws.

I have read and agree to the above payment policy.

Responsible Party Signature: ____ Date: ____________________

Responsible Party Printed Name: ____ Date: ____________________

I hereby authorize insurance payment directly to Westown Dental, LLC. for dental work in their office.

Responsible Party Signature: ____ Date: ______________________

Responsible Party Printed Name: ____ Date: ______________________

Supplemental Medical History Questions

Do you have a congenital heart defect that has not been repaired? No Yes

Have you had a heart valve replacement of any type? No Yes

Have you ever had infective endocarditis? No Yes

Has an orthopedic surgeon told you that you need antibiotics before dental treatment because you have had a joint replacement, pins, or other joint repair? No Yes

So that we may provide the best care possible, are there any special needs conditions that have not already been listed, including Autism, Cognitive Impairment, chromosomal conditions, or syndromes?

No Yes ____

If you are in a wheelchair, can you easily move to our dental chair for treatment? No Yes N/A
We are able to accommodate you in your wheelchair in specially designed rooms in our sedation center.

Office Protocol Regarding Dental Treatment of Children

We treat patients of all ages, and recommend an introductory visit beginning at about age 6 months, when the first primary teeth appear. We want to get your child off to a healthy start!

Our office follows the recommendations and protocols of the American Dental Association and the American Academy of Pediatric Dentistry. While we always have an assistant in the room who also serves as a chaperone, we do not have parents in the treatment room during actual treatment. Dental treatment involves instruments and equipment that is sharp and/or spinning at 400,000 rpms. Even well-intentioned parents inadvertently cause distraction at critical moments, which can result in injury. An exception is the introductory and cleaning appointments under age 3, where the child will sit on your lap. We will take excellent care of your child.

We will involve you in the treatment-planning process, we encourage questions, and we will keep you informed of any issues that arise during treatment. In some cases, based on anxiety and cooperation levels, extent of treatment needed, or medical conditions, we might recommend treatment under some form of sedation. All of our decisions are made with your child's dental and overall health in mind.

I have answered questions to the best of my knowledge and understand and agree to the office policies that have been communicated to me.

____ ______________

Patient, Parent, or Legal Guardian Signature Date

____

Printed Name

Patient Survey

Name: ______________________________ **Date:** ________________

1. How did you find us? (Check all that apply)

☐ Insurance Provider List
☐ Friend / Family
☐ Facebook, Instagram, Yelp, etc.
☐ Google, Yahoo, Bing, etc.
☐ Billboard
☐ Email
☐ Newspaper / Magazine
☐ Internet Ad
☐ Website
☐ Postcard
☐ Radio
☐ VA, Medicare, Medicaid, State Assistance
☐ Drove by location
☐ Other Sleepy Tooth Group Doctor: __________
☐ Other Doctor: ______________
☐ Other (Please Specify): _______________

2. Tell us about you!

Favorite Movie: ________________
Favorite Food: ________________
Favorite Show: ________________
Dream Vacation: ________________
Dream Job: ________________
Dream Car: ________________

3. Why did you choose our office? (Check all that apply)

☐ Convenient location and hours
☐ In-network with Insurance Provider
☐ Online reviews
☐ Other (Please Specify): ________________
☐ Recommended by Friend / Family: ______________________________

4. If you had to choose... (Circle your answers)

Dogs / Cats
Coffee / Tea
Coke / Pepsi
Cabin in the Woods / Beach Front Villa
Chocolate / Vanilla
McDonald's / Burger King
Movies / Books
Starbucks / Dunkin'

The Sleepy Tooth GROUP®

Staff Initials

____

WESTOWN DENTAL, LLC.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature   Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)

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Westown Dental, LLC.

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the HIPAA Privacy Rule

PATIENT INFORMATION

Patient's Name: ___________________________________

Date of Birth: _____________________________________

I, the above named patient, give my consent to release ALL my Protected Health Information (including: Account & Payment Info, Insurance, Appointments, Test Results & X-Rays, Care and Treatment) **by any of the following methods** (but not limited to written, photocopy, paper, electronic formats, verbal, fax) **to the following parties**

1. Name: ____ Relationship: _________________________

2. Name: ____ Relationship: _________________________

(If more space is required, please let us know)

****I DO NOT** WISH ANY INFORMATION TO BE RELEASED Signature: __________________________

I understand that I have the right to revoke this authorization at any time, and that my revocation must be in writing. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I may inspect and/or copy the information to be disclosed. If I have any questions about disclosure of my health information, I may contact the privacy officer to request a copy of this authorization. I understand that I need not sign this authorization to assure treatment, and authorizing this disclosure is voluntary.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics.

A photocopy and/or facsimile of this authorization shall be considered as true and valid as the original.

_________________________________ _______________________________

Signature of Patient (Parent or Guardian) Date

____

Printed Name

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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WESTOWN DENTAL, LLC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: Privacy Officer, Westown Dental, LLC.

Telephone: (302) 376-3750

Address: 818-820 Kohl Avenue. Middletown, DE 19709

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