Langtree Dental Associates
136 FAIRVIEW RD. SUITE #100
MOORESVILLE, NC 28117
PH: 704-662-0021 FAX:704-662-0026 EMAIL: Info@LangtreeDentalAssociates.com

PATIENT INFORMATION

Name: _____ Today's Date:_____

Date of Birth: _____ Social Security: _____

Address: _____
(Street, Apt. #)

_____
(City/Town) (State) (Zip Code)

Contact Information: _____ _____
(Home Phone) (Cell Phone)

_____ _____
(Work Phone) (Email Address)

Responsible Party: _____ Phone #: _____
(Parents/Guardian) (If not the same)

Emergency Contact: _____ _____
(Name) (Phone Number)

_____ _____
(Name) (PhoneNumber)

Pharmacy: _____ _____
(Name) (Phone Number)

Family Physician: _____ _____
(Name) (Phone Number)

When was the last time you saw a dentist? _____

Whom may we thank for referring you to our practice? _____

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OFFICE POLICIES / TREATMENT AGREEMENT

1) Except for emergencies, please try to keep your dental appointments to stay in compliance with your treatment plan. If you cannot keep your appointment, please try to contact our office to advise us. If you miss two appointments; the office can choose to release you as a patient.

2) Please make sure we have your most recent insurance card before your next appointment. If we are not able to verify active status with your insurance the day of your appointment, it is possible that it may delay your treatment or you may not be able to be seen. **The patient will be responsible for anything that the insurance company does not cover or pay for.**

3) Be prepared to pay CASH for your dental co-payment each visit. We accept debit and credit cards for charges totaling $10.00 or more. For dentures, partials or crowns, there is a 50/50 split payment plan. If you do not have your co-payment on the day of your appointment, please check with the office manager for your payment requirement or options according to your insurance situations.

4) Due to legal and liability reasons, if the patient is younger than 18 years old or is a resident of a Group Home, Assisted Living, Nursing Home or Social Services, the parent, guardian or nursing staff is required to stay at the office during the whole appointment. If the patient is dropped off and left unattended, the patient WILL NOT BE TREATED and we will attempt to contact their guardian for pick up.

5) **MEDICATIONS:** You are **required** to be examined before any medication is prescribed. **NO EXCEPTIONS!!** You must ask the doctor for any type of medication to be prescribed. Once the doctor leaves the room, prescriptions will not be discussed. All medications prescribed will be monitored. Alternate pain options and treatments will be discussed with the doctor. If you are a patient of a pain management clinic, you are required to let us know. We are NOT a pain management clinic and will not be abused.

6) **If you bring small children with you to your appointment, you will need to reschedule. Our staff cannot watch your children or be responsible for them while you are being treated.**

7) **Please be considerate of the content, language and noise level of your conversations, as we are a family friendly office. We would appreciate no disturbing behavior since our dentists and employees need to concentrate on the patient's treatment. If the behavior becomes disturbing or offensive to anyone, you will be asked to leave.**

8) ***Due to emergencies or unexpected delays in treatments, you may have to wait. If you cannot wait, please inform our staff so we can pull your chart out of line and reschedule your appointment.***

I acknowledge that I have read and understand the above statements and agree to adhere to them as a patient of this office.

Patient/Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Langtree Dental Associates

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on his Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Langtree Dental Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays Other_____
❑ Spouse (provide name & phone number) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Parent (provide name & phone number) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Other (provide name & phone number _____	❑ Financial ❑ Medical as follows _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Appointment Cancellation Policy

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to keep their scheduled appointments.

How To Cancel Your Appointment

In order to be respectful of the needs of all our patients, if it is necessary to cancel your reserved appointment we require that you contact our office by 10:00 am **two (2)** working day in advance. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care. To cancel an appointment, please call **704-662-0021** to speak with an office representative. If you do not reach an office representative, you may leave a detailed message on the office voicemail. You may not cancel a scheduled appointment via email.

No Show Policy

A **'no show'** appointment occurs when a patient misses an appointment without canceling by 10:00 am **one (1)** working day in advance. No shows inconvenience patients who need access to dental care in a timely manner. **Last minute/late cancellations** are considered **'no show'** appointments.
Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a 'no show'. The **first 'no show'** will result in a **$35- fee** being applied to your account, as well as a call alerting you that an appointment was missed without canceling. If there is **a second 'no show'** a **$50-fee** will be billed to your account and a second call will be made. **A third 'no show' will result in suspension of services and dismissal from our dental practice. Exceptions to this policy must be approved by the Office Manager.**

By signing below, I certify that I have read and understand the terms and conditions of Langtree Dental Associates' appointment cancellation policy:

X_____

Patient Signature **Date**