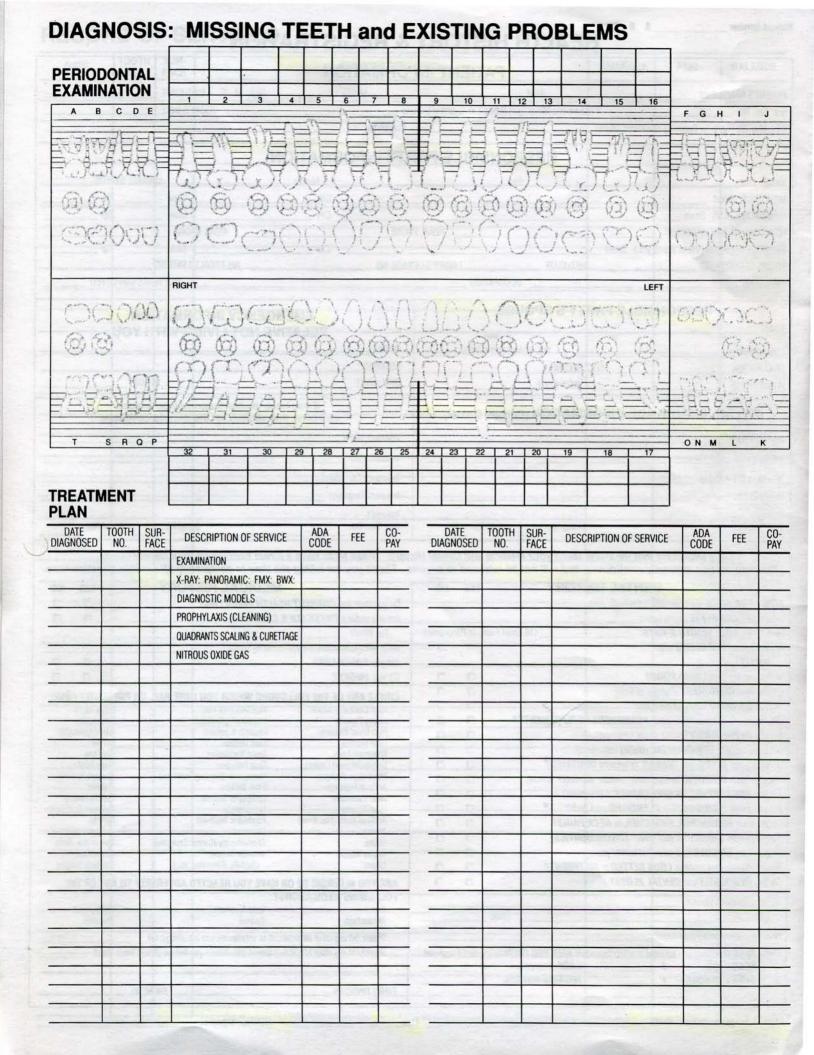
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HEALTH HISTORY & REGISTRATION

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PATIENT Signature (Parent of Child)

Date

DENTIST Signature _____

#### **OUR FINANCIAL POLICY**

We are committed to providing you with the best possible care, and we are please to discuss fees with you any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask I you have any questions about our fees, Financial Policy, or your financial responsibilities.

All patients must complete and sign our "Patient Registration Forms" completely before seeing the doctor.

FULL PAYMENT IS DUE AT THE START OF TREATMENT.

NO POST-DATED CHECKS WILL BE ACCEPTED.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD & AMERICAN EXPRESS. Please note that a 3.5% surcharge is imposed on all credit card payments. No surcharge is applied on debit cards.

#### REGARDING INSURANCE

**PPO/TRADITIONAL INSURANCE** – I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor. Therefore, I am still responsible for all dental fees. As a courtesy to me, Everlasting Smiles is submitting all claims to my insurance company on my behalf. However, my patient's portion is expected in full at the time services are rendered unless prior arrangements have been made. I am also assigning all insurance benefits (payments) to the Doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have already paid all dental fees incurred. Please note that insurance payments are paid based on an estimated percentage and any unpaid charges from the insurance company for services performed also becomes the patient's responsibility. I further understand that a late charge will be added to any overdue balance after 30 days.

#### **MINOR**

The adult accompanying a minor, and his/her parents (or guardians), is responsible for full payments at the time of service. For unaccompanied Minors non-emergency treatment will be denied unless charges have been preauthorized by parents at the time of service.

#### MISSED APPOINTMENTS

We will make every effort to arrange appointments that fit into our schedule. We do ask that you kindly give us **48 hours'** notice should an emergency prevent you form keeping your appointment to avoid a BROKEN APPOINTMENT CHARGE (\$70) ADDED TO YOUR ACCOUNT. This will also allow us to accommodate other patients in need of treatment. Should you habitually miss appointments, we reserve the right to dismiss you from our practice.

#### **COLLECTION POLICY**

If for any reason, there is a balance on your account that has not been paid after **90 days:** your balance will be forwarded to our collection agency (Capital Accounts). At that time, you will be responsible for the collection fee of (30% of outstanding balance) and the balance owed to the office.

Thank you	for understand	ding our Financi	al Policy. Pleas	se let us know if y	our have any	questions or c	oncerns.
-		0			,	1	

RESPONSIBLE PARTY SIGNATURE	DATE

### William Ma D.M.D 4397 Northlake Blvd Ste 202 Palm Beach Gardens, Fl 33410 561-622-8013

## 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 rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this 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 our 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:

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

•	to you to confirm appointments?	YES
	wering machine at home or on your cell phone	
May we discuss your medical conditi	on with any member of your family?	YES
If YES, please name the members, al		
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