EDG | ELMWOOD DENTAL GROUP LLC

Ana Paula Gomes, DMD **Rupal S. Patel, DMD**

Welcome!

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can.
We look forward to working with you in maintaining your dental health.

Office Policies

Thank you for choosing us as your dental provider. We are committed to your treatment being both a pleasant and successful experience. The following is a statement of our policies.

1. **Children under age 18 are to be accompanied by an adult authorized to make treatment decisions and necessary payment for that child.** We are happy to submit to an ex-spouse's dental insurance plan, but ultimately, the financial responsibility belongs to the parent who accompanies the child to the dental appointment.

2. **A courtesy confirmation service is available to our patients who have email and/or texting capabilities. A courtesy phone call will be made to confirm appointments for patients who prefer it.** If you should need to reschedule, we kindly request that you contact us by phone 48 hours before your dental appointment.

3. **Our primary goal is patient care, comfort, and satisfaction.** It is important to understand that Elmwood Dental Group does not treat patients according to insurance coverages, but according to individual patient dental needs. Our utmost concern is always your dental health.

Appointment Responsibility

We encourage patients to arrive 5 to 10 minutes before their scheduled appointment time to help with updating paperwork or information if needed. We do understand that unexpected conflicts and emergencies may arise, however, failing your appointment or cancelling without 24 hour notice prior to your scheduled appointment time more than once may result in a $50 broken appointment fee. We are sensitive to the fact that every patient's time is important and valuable.

1132 New Britain Avenue * W. Hartford, CT 06110 * Tel: (860) 236-6928 * Fax: (860) 236-6920

Email: frontdesk@elmwooddentalllc.com

EDG | ELMWOOD DENTAL GROUP LLC

Ana Paula Gomes, DMD Rupal S. Patel, DMD

Financial Policies

Fees for treatment are due at the time of treatment. An estimate of treatment cost may be available prior to treatment, if you desire. In our continued commitment to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment:

- For non-insured patients, a 5% discount for full payment by cash or check at time of treatment
- Payment by credit card: Visa, Mastercard, Discover, American Express
- 50% of your balance due at start of treatment, with remainder paid at completion.
- Care Credit line of credit
- For non-insured patients, an in-house dental savings plan is available for purchase and enrollment which would give the patient(s) enrolled an increased savings on dental care.

A finance charge of 1.5% will be added to all invoices over 30 days old.

In the event that a personal check does not clear the bank, an overdraft fee of $35 will be charged for reprocessing. This fee may be subject to change.

As a courtesy, we will process your insurance benefits in our office and accept payment on your behalf. All questions regarding your insurance benefits must be addressed to your insurance carrier.

We are here to assist you. Please make your questions and concerns known to our dental team. Our goal is to ensure that you have an outstanding experience. We appreciate your cooperation and look forward to a wonderful relationship.

1132 New Britain Avenue * W. Hartford, CT 06110 * Tel: (860) 236-6928 * Fax: (860) 236-6920

Email: frontdesk@elmwooddentalllc.com

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 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 the notice about our privacy practices, our legal duties, and your rights concerning your health information. We follow the privacy practices that are described in the notice while it is in effect. This notice takes effect July 12, 2007 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.

Uses and Disclosure of Personal Information

We use and disclose health information about you for treatment, payment and healthcare options. For example:

Treatment: We may use or disclose your health information to a physician or other health care 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 performance, conducting training programs, accreditation, certifications, 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 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 persons 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 us to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of heath information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. 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, 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 military authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Confirmation: We may use or disclose your health information to provide you with appointment confirmations such as phone calls, text messages, emails, or voicemail messages.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time.

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 options, and certain activities, but not before July 12, 2007. 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.

Restrictions: 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.

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 website or by electronic mail (email), you are entitled to receive this notice in written form upon your request.

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 Officer: Dr. Ana Paula Gomes
Elmwood Dental Group
1132 New Britain Avenue
West Hartford, CT 06110
Phone: (860) 236-6928
Fax: (860) 236-6920

EDG | ELMWOOD DENTAL GROUP LLC

Ana Paula Gomes, DMD **Rupal S. Patel, DMD**

Receipt of Privacy Practices

I understand that, under the Heath Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 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 (i.e. insurance, financing companies)
- conduct normal health care operations such as quality assessments and physician certifications.

Please list any persons authorized to have access to your health information. This may include friends or family members and may be utilized for booking and confirming appointments, reviewing treatment, or billing.

Name: _______________________________ Relationship: ______________________________

Name: _______________________________ Relationship: ______________________________

Name: _______________________________ Relationship: ______________________________

I authorize contact from this office regarding appointment confirmations, treatment information, and billing by the following methods:

Email: _____ Voicemail: _____ Text message: _____ Cell phone: _____

Home phone: _____ Work phone: _____

I acknowledge that I have received a copy of 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 to obtain a current copy of the Notice of Privacy Practices.

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.

Print Patient Name ____

Patient/Guardian Signature____

Relationship to Patient ___________________________________Date ____________________

1132 New Britain Avenue * W. Hartford, CT 06110 * Tel: (860) 236-6928 * Fax: (860) 236-6920

Email: frontdesk@elmwooddentalllc.com

EDG | ELMWOOD DENTAL GROUP LLC

Ana Paula Gomes, DMD **Rupal S. Patel, DMD**

PATIENT INFORMATION

Name: ______________________________________
(first) (middle initial) (last)

I prefer to be called: ___________________________

Check all that apply: Male: ___ Female: ___

Single: ___ Married: ___ Other: ___

Birth Date: ____________ SSN: _________________

Home address: ______________________________

City: ________________ State: ___ Zip: __________

Home Phone: ____________________

Work Phone: __________________ Ext: __________

Cell Phone: ______________________

Email: ______________________________________

Whom may we thank for referring you?

____

PRIMARY DENTAL INSURANCE

Insurance Company Name: ____________________

Subscriber ID: ______________________________

Group Number: _____________________________

Policyholder's Name: _________________________

Relation to Patient: __________________________

Policyholder's Birthdate: ______________________

Policyholder's SSN: __________________________

Policyholder's Employer: ______________________

SECONDARY DENTAL INSURANCE

Insurance Company Name: ____________________

Subscriber ID: ______________________________

Group Number: _____________________________

Policyholder's Name: _________________________

Relation to Patient: __________________________

Policyholder's Birthdate: ______________________

Policyholder's SSN: __________________________

Policyholder's Employer: ______________________

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment to a recommended specialist, or for the purpose of processing dental claims for insurance benefits.
- I authorize my insurance benefits be paid directly to Elmwood Dental Group.
- I understand I am responsible for any remaining unpaid balance due.
- I have read, understand, and agree to the office policies of Elmwood Dental Group.
- I attest to the accuracy of the information provided on these forms.

Patient or Guardian Signature: ____

Relationship to Patient: ________________________________ Date: ____________________

1132 New Britain Avenue * W. Hartford, CT 06110 * Tel: (860) 236-6928 * Fax: (860) 236-6920

Email: frontdesk@elmwooddentalllc.com