Advanced DENTAL CENTER

A Smile is never just a Smile.

Thank you for choosing Advanced Dental Center of Excellence as your new dental home. We are committed to providing you the highest quality dental care in a caring, trusting, and comforting environment. If you have any questions while completing the form below, please do not hesitate to ask for our help. We are here to serve you and we are always happy to help in any way.

Patient Name_____ Date_____

Address_____ City/State/Zip_____

Phone ( ) _____ Date of Birth_____ Age_____

Email address_____ how may we contact you by phone □ email □

Social Security_____ Sex M / F How did you find us? _____

Marital Status: □ Single □ Married □ Separate □ Divorced □Widowed

Person Responsible for Account / Policy Holder

Relationship to Patient_____

Name_____ Date of Birth_____

Address_____ City/State/Zip_____

Social Security _____ Driver's License_____

Home Phone ( ) _____ Work Phone ( ) _____

Employer_____ Position_____

Today's visit will be paid by: □ Cash □ Check □ Credit Card

PRIMARY Dental Insurance

Ins. Co. Name_____
Ins. Address_____
Ins. Phone ( ) _____
Group / Plan_____
Effective Date_____
Insured Name_____
Address_____
_____
Date of Birth_____
Social Security_____
Employer_____
Do you have a personal physician? □ Yes □ No
Physician's Phone_____

SECONDARY Dental Insurance

Ins. Co. Name_____
Ins. Address_____
Ins. Phone ( ) _____
Group / Plan_____
Effective Date_____
Insured Name_____
Address_____
_____
Date of Birth_____
Social Security_____
Employer_____
Medical Physician's Name_____
Date of Last Visit_____

Emergency Information: Please list the names and telephone numbers of two relatives (or friends) *not living with you* that we may contact in the case of an emergency.

Name_____ Name_____

Relationship_____ Relationship_____

Phone ( ) _____ Phone ( ) _____

FINANCIAL AND INSURANCE POLICY

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the doctor. Payment of services is due at the time services are rendered. We accept cash, check, and credit cards and approved financing.

We may file your insurance claim for you as a courtesy and may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
    - If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefits plans will never pay for completion of your dental care. It is only meant to assist you.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary".**
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. **I understand that employees of Advanced Dental Center of Excellence, PA. are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.**
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay, you are responsible for your payment.
6. If your insurance company does not pay in full within 45 days, we may require you to pay the balance.
7. There will be a fee charged for returned checks.
8. Balances older than 60 days may be subject to collection placement fee of $15.00.
9. I authorize payment from my insurance carrier be made directly to the dentist.
10. I authorize this office to release necessary medical or dental information.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account. We have a number of different financial arrangement options available.

FIXED OR REMOVABLE PROSTHETICS, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made. We accept insurance for payment for the covered portion; however, you must pay your portion at the time services are rendered. PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND PROPER FIT. If you fail to have your prosthetics permanently seated within 60 days from date of impression, a second impression must be made; you will be charged an additional amount. ALL X-RAYS TAKEN ARE A PART OF OUR PERMANENT RECORDS. THERE IS A DUPLICATION CHARGE FOR ANY X-RAYS REMOVED FROM THIS OFFICE.

We will make every effort to confirm your appointment the day before. If an appointment cannot be kept, kindly give 24 hours notice during business hours so another patient may have your time slot. There will be a $50 charge if 24 hours notice is not given. If a patient is more than 20 minutes late, we do reserve the right to reschedule if the procedure interferes with another patient's appointment time.

Again, thank you for choosing Advanced Dental Center of Excellence as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

_____ _____

Patient or Guardian Signature Today's Date

Advanced Dental Center
Christine Hopkins, DDS, MS
6541 Preston Rd Suite 100
Plano, Texas 75023

Appointment Reminders. Your contact information may be used by our staff to send you appointment reminders. If you do not want us to contact you via phone numbers or email address you have already provided, and/or leave a voice message via those numbers, please check the following box (es):

☐ Please do not contact me via the phone numbers provided to this practice.

☐ Please do not leave a voice message via the phone numbers provided to this practice.

☐ Please do not contact me via email provided to this office.

Canceling or Rescheduling an Appointment

In order to help our office run more efficiently, provide the best quality care possible, and keep your cost to the minimum, our office require 24 hours advance notice if there is a need of rescheduling/canceling the appointment.
There will be a $50.00 fee charged if any changes made within the 24 hours of scheduled appointment or no show (exclude true emergency).

Please sign this form, stating that you have read and fully understand our Cancellation/Rescheduling policy.

Patient
(Or responsible party-if patient is underage)

Signature_____ Date_____

Advanced Dental Center
Christine Hopkins, DDS, MS
6541 Preston Rd Suite 100
Plano, Texas 75023

Dental Treatment Consent Form Patient Name:_____

1. **Health Information**
I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.

2. **Drugs, Latex and Medicines**
I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heart beat and, depending on my health, may be dangerous to me.

3. **Needle Stick**
If someone is inadvertently stuck with a needle used on me, I consent to have my blood drawn for analysis.

4. **Fillings, Crowns and Un-anticipated Root Canals**
Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

5. **Root Canals can fail**
Root canals can fail and may require additional treatment or I may end up having the tooth extracted.

6. **Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings**
Porcelain crowns, veneers, cosmetic bonding and fillings are esthetically pleasing. However, I understand they if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, binding or filling is placed, I understand the color cannot be changed.

7. **Gum Treatment and requesting "Just a cleaning"**
If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).

8. **Extractions and surgery**
I understand that all dental extractions or surgeries carry risks. Some are minor like a dry-socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis.

9. **Fee for additional or specialty care**
I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

10. **Limitations of Insurance Coverage**
There are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only and estimate. I agree to be financially responsible for what insurance does not cover.

11. **24 hour notice for cancellation**
I agree to give 24 hr notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office has closed the day (or weekend) before is NOT sufficient notice.

12. **Requesting Record Transfers**
Professional courtesies are between dentists. I agree not to request records until I have a new dentist.

13. **Hygiene Appointments**
If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

I do not expect guarantees in dental care. I have read the above and consent to treatment.

_____ _____ _____

Signature of Patient or Parent of minor Date Witness

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 their 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 the 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.

Uses and Disclosures of Health Information

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare providers providing treatment to you.
Payment: we may use and disclose your health information to obtain payment or 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 you health information or o 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 when 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 their Notice of allowed under the Law.
To Your Family and Friends: we must disclose your health information to you, as described in the Patients 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 you location, your general conditions, 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 your 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 reasonable 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We ay use or disclose a portion of 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 obtain 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 can not 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 0.10 for each page, $18.00 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 instance 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 nor 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 of how payments will be handles 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 with we may have violated our 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 may also 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 no 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: Dr. Christine Chang Hopkins
Telephone: 972-781-0209 E-mail: info@smilesbyadc.com
Address: Advanced Dental Center, 6541 Preston Rd. Suite 100, Plano, Texas 75024

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of the Advanced Dental Center of Excellence's Notice of Privacy Practices.

Please Print Name

Signature

Date

(NOTE: PLEASE ADD THIS SIGNED FORM TO THE "CONSENT" SECTION OF THE STANDARD RECORD OR ENCLOSE IN THE EMERGENCY PATIENT RECORD)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Advanced Dental Center of Excellence's Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____
_____
_____

If you have any concerns regarding dental services that have been provided, you can contact the State Board of Dental Examiners at the following address:

Texas State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, Texas 78701-9342