RIVER OAKS
Dental Arts

Welcome to the Practice

Patient Information Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City/State _____ Zip Code _____

Driver's License # _____ Name of Employer _____

Check appropriate box □ Minor □ Single □ Married □ Divorced □ Widowed

Contact Numbers (H) _____ (W) _____ (C) _____

Email _____

How do you prefer that we contact you? ___ Telephone ___ E-mail

Person to contact in case of emergency _____ Relation_____ Phone _____

Responsible for account- Check one □ Patient □ Guardian □ Spouse □ Father □ Mother

Whom may we thank for referring you? Friend or Family Member _____

Other Referrals □ Internet □ Coupon □ Doctors Referral □ Magazine □ Walk by □ Drive by

I am interested in (Please check all that apply)

□ General Dentistry

□ Cosmetic Smile Makeover

□ Teeth Whitening

□ Invisalign or Straighter Teeth

□ TMJ or Teeth Grinding

□ Snoring/Sleep Apnea

RIVER OAKS
Dental Arts

Dental Records Release Form

If you would like your dental records and x-rays transferred from another office, please fill out the top half of the form so we can send it to your previous dental office. This form authorizes them to release your records to our office. If you want your records forwarded to another office then please fill out the bottom part of the form. Thank you for completing this records release.

Patient Name: _____ Date of Birth: _____
Contact Number: (H)_____ (W) _____ (C) _____
Other family members to transfer: _____

Previous Dentist or Practice Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to River Oaks Dental Arts.

I hereby give you permission to release any and all of my dental records to Dr. Testa.

_____ _____
Patient Signature (parent if a minor) Date

If records are digital, please email to:
scheduling@riveroaksdental.com

Or mail to:

River Oaks Dental Arts
Dr. Palmira Testa
1436 West Gray St
Houston, Texas 77019

Request to Release Records from River Oaks Dental Arts (Please check one of the boxes)

- o Forward my dental records to another dentist
  Dentist/Practice Name _____
  Address _____
  Telephone Number _____ Email _____

- o Forward my dental records to me for my own files (Choose one- Email or Mail)
  Email _____
  Mailing Address _____

_____ _____
Patient Signature (parent if a minor) Date

RIVER OAKS
Dental Arts

Office and Financial Policies

Thank you for choosing River Oaks Dental Arts to care for all your dental needs. Our goal as your dental care provider is to create a pleasant and comfortable experience both in the dental chair and at the financial desk.

In order to provide comprehensive quality care to our patients, we are an **out of network provider**. As a courtesy to our patients, we will verify your insurance eligibility and benefits before your initial visit and any time that you notify us of a change in your coverage. However, we cannot guarantee that the information we receive is accurate (at the time of verification or for later visits) or that the insurance company will process the insurance claim in accordance with the information they provided. You, as the holder of the insurance policy, are ultimately responsible for knowing what your plan does and does not cover and the administrative rules (such as referrals, authorizations, etc.).

Any amounts not covered by your plan, are your responsibility. Please take some time to read over our Office Policies below so that we can establish a mutual understanding of any situations that could arise. Please read and initial each item below.

APPOINTMENTS:

- For your convenience our office hours are as follows: Mondays, Wednesdays and Thursdays from 7:30 a.m. to 3:30 p.m. with a lunch hour that varies. Tuesdays from 10:30 a.m. to 6:30 p.m. with a lunch hour that varies. We do see patients on one Friday a month but the schedule varies.
- Please be on time for your reserved appointments. We have exclusively reserved the doctor, staff, and facility for your personal dental care. If you need to cancel or reschedule an appointment, please let us know **48 hours** in advance**. If an appointment is cancelled or rescheduled within the 48 hours before the appointed time, $50.00 per scheduled hour will be charged to your account.**
- If you are thirty or more minutes late for our appointment it will be considered a **"no show"** and rescheduled to another day. **You will be assessed a $50.00 per scheduled hour charge to your account.**
- For any appointment's scheduled for **two hours or longer we require 20% NON REFUNDABLE DEPOSIT** of the total treatment scheduled for that day. We will retain the deposit if the appointment is cancelled or rescheduled within 48 hrs before the appointment.
- We encourage our patients to tell their family and friends about us. If you refer someone to our practice you will receive a $25.00 credit towards your next dental appointment and they will receive 50% off of a Complete Examination and Full Mouth X-rays. (*Initials* _____)

FEES:

- Our office believes our fees are a fair representation of the standard of care we provide, and are in-step with the industry standard. It is having a fee for service practice that allows us to deliver the first class quality and services you desire. Fees quoted in treatment plans are honored for **six months** and after that are **subject to change** without prior notice. The treatment plan will be updated with the current fees.
- We request that you give our office two business days to prepare records and X-rays for transfer; otherwise there will be a $25.00 charge. (*Initials* _____)

COPAY AND DEDUCTIBLES:

- **Estimated patient out of pocket and deductibles are due at every visit**. If there is a deductible to meet, I will pay my estimated portion plus the deductible. I understand that the insurance benefits available are conditional on the patient's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. The benefits quoted are not a guarantee of payment. Final determinations to benefits payable will be made at the time the claim is submitted for payment. **Benefits not paid by the insurance company are the responsibility of the patient.** (*Initials* _____)

BALANCES:

- After my insurance plan has processed the insurance claim, remaining balances are due immediately upon receipt of a bill from the office. If I disagree with the amounts due per the insurance Explanation Of Benefits, it is my responsibility to immediately contact my insurance company for resolution of the problem. **I understand that I may not withhold payment to River Oaks Dental Arts pending resolution of the insurance problem**. If the insurance corrects the problem, I understand my account will be credited or I will be refunded any overpaid amounts.

(*Initials* _____)

NEW INSURANCE INFORMATION:

- New insurance information must be provided prior to my appointment date. I agree to provide this information before I am seen. Failure to provide correct insurance information may result in the entire bill being my own responsibility.

(*Initials* _____)

INSURANCE REQUESTS FOR ADDITIONAL INFORMATION:

- I understand that insurance requests for additional information necessary to process claims must be responded to immediately. These include requests to verify other insurance coverage, full-time student status, etc. Failure to provide this information in a timely manner may result in the entire bill being my responsibility.

(*Initials* _____)

PAYMENTS:

- Payment is due when services are rendered. An estimate of your treatment fees will be outlined in detail with you at the time of your initial visit, or at a follow up treatment consultation.
- We accept Cash, Personal Checks, Visa, MasterCard, Discover, and American Express.
- We also work with 3rd Party Financing companies: Care Credit (*Initials* _____)

BILLING:

- Bills are sent out at the beginning of the month and as needed throughout the month. Please remit payment for or contact the office to pay by credit card any balances due immediately upon receipt of a bill. I agree to contact the office immediately if I have questions regarding a bill I receive. (*Initials* _____)

MISSED APPOINTMENTS:

- I agree to cancel scheduled appointments at least 48 hours in advance. Failure to do this will result in a No Show Fee of $50 per hour per patient to be added to my account. I understand that I can cancel an appointment by calling the office or emailing the scheduling coordinator.

(*Initials* _____)

BALANCES OVER 90 DAYS:

- I understand that if I allow my account balance to exist more than 90 days, I may receive a Final Notice Letter. Failure to pay my account or make arrangements with the office within 10 days may result in my account being turned over to a collection agency. The collection fees incurred due to the delinquent account will become my responsibility. I understand that will be dismissed from the practice and will have to find another physician within 30 days. I understand that the collection agency will report unpaid balances to all major credit bureaus. Before I can be seen in this office again, I understand that all fees, commissions, and taxes relating to collection agency involvement must be paid.

(*Initials* _____)

CHANGES IN ADDRESS:

- Changes in address or telephone numbers should be provided immediately. I will not wait until the next appointment, as bills or other correspondence will not reach me without a valid address on file. I understand that if the office cannot contact me via telephone or mail, my account will be turned over to a collection agency for further collection activity. (See Balances Over 90 Days for additional information on collection policies)

(*Initials* _____)

RETURNED CHECKS

- A $25 fee will be incurred if a check is returned. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. If a second check is returned on my account, I understand that the office will no longer accept personal checks for payment. (*Initials* _____)

Again, we thank you for choosing River Oaks Dental Arts to care for your dental needs. We appreciate your trust and look forward to serving you. If you have any questions regarding our financial policies, please don't hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that you were provided with a copy for your records.

Patient Printed Name _____

Parent/Guardian Printed Name _____

Signature of Patient/Guardian _____ Date _____

RIVER OAKS
Dental Arts

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below, I acknowledge that I have received or reviewed the Notice of Privacy.

I give my consent for the use of my personal health information for treatment, payment, operations and other uses as described in the privacy notice. I grant the right to my dentist to release my dental/medical histories and other information about my dental treatment to my insurance and/or other dental health professionals if needed. I agree with the terms of this notice and understand my rights under this notice.

I also authorize River Oaks Dental Arts to release information to my spouse _____ or friend/family member _____ regarding my health, treatment and financial account.

I also understand that I have the right not to sign this agreement.

Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

If we are unable to get your acknowledgement then our office will make notation to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

_____

_____

_____

Staff:_____

Signature:_____

Date:_____

RIVER OAKS
Dental Arts

Notice of Privacy

As a provider of dental services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

Our Duty To You

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information, about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers, lab technicians, and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as employee medical reimbursement accounts.

Operations: We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages, and letter), abuse/neglect, national security, immediate family and friends (only to the extent for use in healthcare operations or payment), schools (letter excusing absence due to dental treatment), education (use of information in presentations or lectures regarding specific treatment or procedure), advertising, and in some cases to law enforcement and court ordered releases (coroner, worker's compensation, automobile policies, and life insurance policies).

Your Rights

Restrictions: You have the right to request restrictions or disclosure of usage. We are not required to accept these restrictions but we will make a note of the request and honor that request if applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Texas State Board of Dental Examiners.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you can submit a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address upon request.