Sheldon Hough, D. D. S., Inc.
Jennifer Woods, R. D. H.

57463 29 Palms Highway, Professional Suite 204
Yucca Valley, California 92284
(760) 365-2331

The staff and I would like to take this opportunity to welcome you to the office.

Our goal is to provide for your optimal dental health in such a manner that you would feel comfortable recommending our office to your family and friends.

We realize that the Medical/Dental history seems long; but, we derive great satisfaction from the comfortable feeling of having an in-depth knowledge of our patients. We find that the preoperative evaluation is valuable in that it teaches us about you, our patient. We strongly believe that the preoperative assessment improves your safety, and that is of paramount importance. For your health's sake, please be accurate.

The treatment summary/informed consent on page four will provide you with some basic dental knowledge. Your knowledge of dentistry will let you, doctor and staff make better decisions about your optimal dental health care. It is important that you always feel you can communicate with the doctor or staff on any phase of your care. We will not perform any treatment without your knowledge and consent.

No matter how hard we endeavor, there is always the possibility of a misunderstanding or a perceived lack of services. Please, we do not want to risk our relationship with you... If there is a concern, please let us know. We are here because of your support, not the other way around.

Thank you for giving us the opportunity to serve you.

PATIENT REGISTRATION / HEALTH HISTORY / INFORMED CONSENT

Date _____

Patient's Name _____ Date of Birth _____ Age _____ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated ☐

What Name Would You Like to be Addressed by _____

Name of Spouse _____

If a Child, Mother's Name _____ Date of Birth _____

If a Child, Father's Name _____ Date of Birth _____

Mailing Address _____ Phone _____

City _____ State _____ Zip _____

E-mail _____ Cell Phone _____ Fax _____

Patient (If a Child, Father) Employed by _____ Phone _____

Business Address _____

Present Position _____ How Long Held _____

Spouse (If a Child, Mother) Employed by _____ Phone _____

Business Address _____

Present Position _____ How Long Held _____

Person Responsible for this Account _____

Patient's Social Security Number (not father's or mother's) _____

If a Child, Father's Social Security Number _____ If a Child, Mother's Social Security Number _____

If Using Charge Card, Name _____ Card No. _____ Exp. Date _____

If You Have Insurance, Name of Insured(s) _____

Name of Insurance Company(s) _____ Policy No. (s) _____ Group Number _____

Purpose of this Appointment _____

In Case of Emergency, Who Should be Notified _____ Phone _____

Whom May We Thank for Referring You _____

Are You Happy with the Appearance of Your Teeth _____

Are You Interested in Whiter Teeth _____

Are You Concerned about Bad Breath _____

Date of last dental visit _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

_____

Have you ever had any serious trouble associated with previous dental treatment? _____

Are You ALLERGIC or experienced any reaction to the following?

	YES	NO
Local anesthetics (e.g. Novocaine)	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐
Penicillin/other antibiotics	☐	☐
Aspirin or codeine	☐	☐
Sulfa drugs	☐	☐
Latex	☐	☐

Other allergies _____

Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medicine	☐	☐
Cortisone/steroids	☐	☐
Antihistamines/allergy drugs	☐	☐
cold remedies	☐	☐
Tranquilizers	☐	☐
Insulin/other diabetes drugs	☐	☐
Recreational drugs	☐	☐
Digitalis/other heart medications	☐	☐
Nitroglycerin	☐	☐
Aspirin	☐	☐

Other medication _____

Please list names of medications, herbs, vitamins, and dosages of drugs you are currently taking:

_____

_____

_____

_____

Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

Do you suspect or do you have the disease AIDS, ARC, or have you been in contact with persons having this disease? _____

Physician's Name _____ Phone _____

	YES	NO
Have you ever taken medication for osteoporosis (Fosamax, Boniva or Actonel)?	☐	☐
Are you in good health now?	☐	☐
Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
Do you use tobacco in any form? If yes, how much	☐	☐
Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐
WOMEN: Are you pregnant now?	☐	☐
Are you practicing birth control?	☐	☐
Do you anticipate becoming pregnant?	☐	☐

Do you have or have you ever had any of the following?

Update Initials

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Glaucoma	☐	☐
Visual change	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other _____		
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Stroke	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other _____		
BONE/MUSCLE		
Artificial joints	☐	☐
Pain in jaw joints	☐	☐
Arthritis/rheumatism	☐	☐
Osteoporosis	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of Urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
OTHER		
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer _____		

Do you have any condition or disease that requires pre-medication (Antibiotics) before dental treatment? _____

If yes, what? _____

Drugs and Medication

Antibiotics interfere with the effectiveness of oral contraceptives. I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphalactic shock.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth that were not discovered during the examination.

Removal of Teeth

Alternatives to removal will be explained to me (root canal therapy, crowns, and periodontial surgery). I understand: 1. removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. 2. the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or a fractured jaw. 3. I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Crowns, Bridges (Caps)

I understand: 1. that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. 2. that I may be wearing temporary crowns, which may not look as good as the final crown and which may come off easily. 3. that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. 4. there will be additional charges for remakes due to my delaying permanent cementation. 5. that significant sensitivity is a common after effect of a newly placed crown, a root canal might be required at my expense. 6. My temporary crown may not look as nice as the final crown. 7. I need to exercise care with my temporary crown so it will not come off or break.

Endodontic Treatment (Root Canals)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root or a file may break off, neither which does not necessarily effect the success of the treatment. I understand: 1. that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). 2. that the tooth may be lost despite all effort to save it. 3. a crown and post build up will be required as a final restoration.

Periodontal Loss (Bone & Tissue)

I understand: 1. that I might have a serious condition, causing gum and bone inflammation or loss and that it can lead to loss of my teeth. If so, alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions. 2. that undertaking any dental procedures may have a future adverse effect on my periodontal condition or that my periodontal condition may have a future adverse effect on my restorative treatment. 3. that even after periodontal therapy by this office that I might still have to see a specialist. 4. that it is important to follow the instructions outlined by this office.

Adhesive Fillings

I understand: 1. That a more extensive filling, crown, or endodontic (root canal) treatment, than originally diagnosed, may be required due to additional decay or breakage. 2. That significant sensitivity is a common after effect of newly placed fillings. If the sensitivity does not decrease in time, a root canal/crown may be required at my expense. 3. Adhesive fillings may not "last as long" as mercury based.

Dentures (Full & Partial)

I understand: 1. the wearing of dentures is very difficult. Sore spots, altered speech, and difficulty in eating are common problems. Temporary dentures (placement of denture immediately after extractions) may be painful. Temporary dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. 2. that it is my responsibility to return for delivery of the dentures. 3. that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake or alterations are required due to my delays of more than 30 days there will be additional charges.

Radiographs (X-Rays)

The use of dental radiographs, or x-rays, allows the doctor to detect dental problems early before serious damage is done to your teeth, gums, and supporting bones and structures. If these conditions are not detected until there are visible or painful signs of disease, your oral health can be seriously affected. Dental radiographs are a part of a comprehensive dental oral examination. I will not hold my dentist liable for any failure to diagnose, or any misdiagnosis due to lack of the recommended x-rays. I assume full responsibility for any conditions relating to my dental health that may have not been diagnosed or misdiagnosed due ot lack of radiographs.

I understand: 1. that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested. 2. that failure to follow any guidelines recommended by this office may be detrimental to my total health. 3. that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. 4. that fees are only estimates and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. 5. that regardless of any dental insurance coverage I may have, I am responsible for all payment of dental fees within 30 days of service. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Should any dispute arise over dental services provided to me, said dispute will be submitted to Peer Review by the local component of The American Dental Association. The decision of Peer Review shall be binding on both parties, I have read, understood, and agree to the above.

If I ever have any change in my health or medication, I will inform the office at my next appointment.

Signature of Patient, Parent, or Guardian _____ Date _____

Control-o-fax 1-800-553-0070 Form No. A-160903-2

SHELDON HOUGH, D.D.S., INC.
YUCCA VALLEY CENTER FOR COSMETIC DENTISTRY
NOTICE OF "HIPAA" PRIVACY PRACTICES

AS OF APRIL 14, 2003 THIS NOTICE, MANDATED BY THE FEDERAL GOVERNMENT, DESCRIBES HOW HEALTH INFORMATION ABOUT YOU OR THOSE YOU ARE RESPONSIBLE FOR, MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THAT INFORMATION THE FEDERAL GOVERNMENT AND HIPAA REQUIRES THAT THE PATIENT OR PATIENT'S PARENT/GUARDIAN READ AND SIGN THIS DOCUMENT BEFORE TREATMENT IS PROVIDED

OUR LEGAL REQUIREMENTS

Although, this office has always worked hard to maintain and protect your privacy, Federal law, State law, and a new government act, "HIPAA", requires us to inform you how we maintain the privacy of your health and personal information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We will try to follow these privacy practices as described in his notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until further notice.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes or such demands take place. 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. When we make a significant change in our privacy practices, we will change this notice and make a new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please ask any staff member.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

TREATMENT: We may use your health information for our treatment; disclose it to another dentist, physician or other health care provider providing your treatment.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for payment activities.

HEALTH CARE OPERATIONS: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the Federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications or health care professionals, or detect or prevent health care fraud and abuse.

YOUR AUTHORIZATION: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any uses of disclosures permitted by your authorization while 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 this notice.

YOUR FAMILY AND FRIENDS: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, you must inform us at this time in writing that you object to this disclosure. Regardless or not if you object; if you are not present, or in the event of your incapacity or and emergency, we will disclose your medical/dental health information based on our professional judgement of whether the disclosure would be in your best medical/dental health care interest. We may 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 prescriptions, medical/dental supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, or your location, and general condition.

APPOINTMENT REMINDERS: We may use or disclose your health information unintentionally to others to provide you with appointment reminders (such as answering machines, voicemail, post-cards, letters, e-mail, fax, or other communication forms).

TELEPHONE/WRITTEN COMMUNICATIONS: We may use or disclose your health information unintentionally to others to provide you with proper health/billing concerns.

ELECTRONIC TRANSFER OF INFORMATION: We may transfer information electronically, ie: computer transfers, Internet, phone lines, or any other electronic transfer technologies.

DISASTER RELIEF: We may use or disclose your medical/dental information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

PUBLIC BENEFIT: We may use or disclose your dental/medical information as authorized by law for the following purposes deemed to be in the public interest or benefit: as required by law; for public health activities, including disease and vital statistic, child

abuse reporting, FDA oversight, and to employers regarding work-related illness or injury; to report adult abuse, neglect, or domestic violence; to health oversight agencies; in response to court and administrative order and other lawful processes; to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to coroners, medical examiners, and funeral directors; to an organ procurement organizations; to avert a serious threat to health or safety; in connection with certain research activities; to the military and to federal official for lawful intelligence, counterintelligence, and national security activities; to correctional institutions regarding inmates; as authorized by state worker's compensation laws.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written permission.

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 reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health/safety or the health/safety of others.

COMPUTERS: Our office uses computer terminals. Patient names may be visible to other patients. No health information is disclosed in this procedure intentionally. Our computers are marked for the general public not to touch.

PAPER RECORDS: Our paper records are not kept under lock and key, yet we believe that they are inaccessible to the general public. Your records will be stored in a private staff area.

STAFF ACCESS: All staff members have equal access to all patient information. All staff members, who are no longer employed by this office have signed an agreement not to disclose any patient information to unauthorized persons under penalty of law.

JOINT TREATMENT/RECEPTION AREAS: Because our office has joint reception/treatment areas rather than individual patient reception/treatment areas, discussions of health information between doctors/staff/patients, these conversations may be overheard by other patients.

DISCARDED PATIENT INFORMATION: A bonded/authorized company destroys all patient documents.

SERVICE/REPAIR PERSONNEL: We will do our best to keep your information private from these personnel. Yet, it must be understood on your part, that these people will sometimes need access to private information to service/repair the technology in our office.

JANITORIAL SERVICES: We will do our best to keep your information private from these personnel. Yet, it must be understood on your part, that these people will sometimes have access to private information to clean our office.

REVISIONS: We reserve the right to revise or change this document either as mandated by government or to better serve our patient in our judgement.

PATIENT'S RIGHTS

ACCESS: You have the right to look at or get copies of your health information with limited exceptions for a fee. You must make a request in writing to obtain access to your health information to the address of this office. If you request copies, we will charge you a cost-based fee that may include labor, copying costs, postage, or other costs.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which our business associates or we disclosed your health information over the last six years (but not before April 14, 2003). That list will not include routine disclosures for treatment, payment, health care operations, as authorized by you, and for certain other routine activities. You will be charged a cost-based fee for this service.

RESTRICTION: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will do our best to abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on your behalf. This office will do its best to honor your request, but will not be held libel for any accidental or unintentional disclosure of that information.

LEGAL ACTION: You use this office at your own risk concerning privacy issues. We will not be held responsible for any accidental or unintentional disclosure of any privacy issues and you give up your rights to any legal action against this office or its staff members or any perceived compensation resulting from such disclosure.

AMENDING: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend such information. We reserve the right to deny your request. The address of the US Dept. of Health and Human Services is listed below if you have any concerns not addressed by this notice.

US Dept. of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, DC 20201

If you want more information about our privacy practices, questions, or concerns: Please contact any staff member.

WE VALUE YOUR PRIVACY AND WILL DO OUR REASONABLE BEST TO PROTECT SUCH...

SIGNATURE OF PATIENT, PARENT, GUARDIAN_____ **DATE**_____

THIRD-PARTY PAYERS

WHAT IS THE DENTIST'S ROLE IN A *patient's dental plan?*

By interceding on behalf of patients, doctors may inadvertently cut employers out of the loop. The result: Plan purchasers may not hear complaints from employees.

The individual who coined the phrase "no good deed goes unpunished" must have had dentists in mind. Dentists' concern and care for their patients goes far beyond the examination, diagnostic and treatment phases of oral health.

Case in point: the willingness of most dentists to take on the responsibility of fighting with insurance companies to see that their patients receive the benefits to which they are entitled–regardless of whether the dentists are contractually involved with their patients' dental plans. This role of unofficial ombudsman, though well intended, is detrimental to both patients and dental practices.

Dentists' intercession on behalf of their patients has unfortunately diverted the normal channels for consumer feedback and has, instead, resulted in insurance companies making scapegoats of dentists. Rather than try to improve their products, insurance companies have laid the inadequacies of their plans at the feet of every dentist who has had the fortitude to oppose third-party interference. And how easy it has become for the insurance industry to portray dentists as incompetent and patients as stupid.

Dentists often are left holding the bag, so to speak, trying to explain the shortcomings of a plan the dentists had no voice in designing or selecting for their patients. Instead, patients should talk to their employers about their plans if they want to see some improvement in coverage.

Employers, not the individual employees (patients), are the actual insurance company customers. The final phase of designing, developing and marketing any product is its acceptance or rejection by purchasers. And critical feedback from consumers communicated to employers either forces improvements in the product or its demise.

Yet, if dentists continue in their ombudsman role, then the endless series of time-consuming telephone calls between dental offices and insurance claims clerks will continue. And employers will never know. On the other hand, if an employer's benefits manager had to spend just a fraction of the time that is spent by dental office staff fighting with the insurance companies over treatment plans, reimbursements and lost claims, those dental plans would be dropped at the first opportunity.

Employers need feedback on the performance of the plans they purchase. Otherwise there is no way that these plans will be improved. Action by employers is the only way that plans will be improved or replaced.

Time to reconsider

Dentists who are not contractually involved with dental plans may want to reconsider their involvement in their patients' plans. (Of course, dentists who are contractually involved as participating providers in dental plans should know their obligations and responsibilities to patients and payers.)

By all means, submit statements and documents as a courtesy to patients, but let the patients and the plan purchasers take it from there. It isn't the job of the dental office to contact an insurance company. If the insurance company's dental consultant wishes to discuss a particular treatment plan with the patient's dentist, that's fine–two professionals discussing the patient's oral health. But the actual dental plan, its coverage and its financial limitations are not and should not become the treating dentist's responsibility.

If you have insurance, please read and sign, thank you

YOU ARE VERY IMPORTANT TO US...WE HAVE TRIED TO PUT TOGETHER A BRIEF OUTLINE OF INSURANCE FACTS TO HAVE YOU BETTER UNDERSTAND THE CURRENT INSURANCE INDUSTRIES' BEHAVIOR AND ITS RELATIONSHIP TO YOU AND THIS OFFICE. THIS INFORMATION IS NOT MEANT TO BE AN AFFRONT, BUT TO KEEP YOU INFORMED. WE HAVE RE-CRAFTED THIS INFORMATION MANY TIMES, AS OUR PATIENTS GAVE US POSITIVE AND SOMETIMES, "NOT SO POSITIVE" FEEDBACK.

Because insurance companies can undermine the relationship between the dental office and its patients, there is a growing trend in the dental profession to stop accepting the patient's insurance. With your help, this is not how we wish to provide for our patients. The American Dental Association has brought a lawsuit against a member of the insurance industry for its current behavior. We would like to continue to help our patients financially by accepting your insurance. But we need your help! We would appreciate that you read the following in order to preserve our special relationship. If you have questions, feedback, or concerns, please let us know.

Facts About Your Dental Insurance

Fact #1: Your dental insurance is based upon a contract between YOUR employer (as a gift to you) and an insurance company. If we provide care, a financial obligation now exists between you and this office. Your employer or your insurance company does not have a financial obligation with our office.

Fact #2: Dental insurance benefits differ greatly from general health-insurance benefits. In 1971, dental-insurance benefits were approximately **$1,000** per year. Figuring a low 6-percent rate of inflation per year: you should be receiving **$5,762** per year in dental benefits as of 2002. Your **PREMIUMS** have **INCREASED,** but many **BENEFITS** have generally **STAYED THE SAME AS 1971!**

Fact #3: You may receive a notification from your insurance company, stating that our dental fees are "higher than usual and customary." An insurance company surveys a large geographic area, calculates an **average** fee, takes 80 percent or less of that fee and considers it customary. Included in this survey are discount dental clinics and managed-care facilities, which bring down the average. The fee-for-service doctor in private practice will have fees that insurance companies define as higher than "usual and customary." Your insurance company never reminds you that its benefits are too low when you look at inflation factors. This is a major part of the lawsuit.

Fact #4: Many plans tell their participants that they will be covered up to 80% or 100% of fees, but do not **clearly specify actual** plan fee-schedule allowances, annual maximums, or limitations. This "double-talk" can be very confusing for our patients.

Fact #5: Many dental services, which by today's standards of care are considered routine, may not be covered or "downgraded". ie: cosmetic-fractured/cracked teeth-wear/abrasion/abfraction-sealants-age restrictions.

Fact #6: Insurance companies are well aware of the fact that if they deny you legitimate benefits, most patients will accept that loss of benefits. Remember, their goal is to create profits for the shareholders. If they are paying out claims, they are making less profit! Many treatment decisions are not based on current scientific clinical evidence. The "dental consultants" that deny your claim are **not** experts. They are on the payroll of your insurance company!

Fact #7: An insurance "Pre-Determination" is not a "Pre-Authorization". A "Pre-Determination" is not a guarantee of payment. Dental insurance companies do not "Pre-Authorize" claims, although their policy verbiage may seem to suggest such.

Fact #8: This office is not the customer of your insurance company, as such; your insurance company is not going to respond to our inquiries with the same diligence as your inquiry. We will help, but it is still your responsibility to "deal with" your insurance company. More and more states are passing, "Patient's Bills of Rights" because insurance companies are not responding to their obligations in a timely manner.

ETHICALLY AND LEGALLY, WE CANNOT BASE YOUR CARE ON WHAT YOUR INSURANCE COMPANY WILL OR WILL NOT COVER. IT IS OUR RESPONSIBILITY TO PROVIDE YOU WITH THE BEST CARE POSSIBLE THAT YOU CHOOSE TO HAVE DELIVERED.

We will be pleased to accept your co-payment at time of service, but we MUST ask that all unpaid balances be paid within 60 days of your care date regardless of your insurance's payment status. To make this convenient for you, our computer can keep track of your credit card (**EZ-Pay®**) and automatically post the unpaid balance after 60 days. If you choose, we will ask for your credit card number when you sign the estimate for treatment. Your commitment to your financial obligation is greatly appreciated.

Please read both sides...Signed_____Staff initials_____

State/HIPAA Regulations &
Office Cancellation Policy

Voted Best Dentist
By The Readers
From The High Desert Star
Since 2012

I HAVE RECEIVED THE DENTAL MATERIAL FACT SHEET

I consent to the dental practice using my cell phone and e-mail to contact me regarding appointment confirmation, appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number and e-mail are:

CELL PHONE #: (_____) _____
Area Code

E-MAIL: _____

Missed, Cancelled, & Late Appointment Policy

We want to thank you for choosing us as your dental health care provider. In order to give you the best possible care, we request that you review our policy regarding missed, cancelled, or late appointments. When we reserve time for you, we require all of that time to provide you with the best quality work possible. A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24 hours. If you arrive more than 15 minutes late for your appointment you may be rescheduled in order to meet the needs of those that are on time for their pre-reserved visit. We understand/acknowledge that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed. If you are unable to keep your scheduled appointment and proper notice is not received, a missed/cancelled appointment fee of $35.00 may be charged to your account. This charge is not covered by insurance. The first missed appointment will be at no charge and we will notify you that you have missed the appointment in order for you to reschedule. The second missed appointment you will receive a missed/cancelled appointment fee.

Please sign and date below stating that you have read, understand, and acknowledge this policy.

Signature _____ Date_____

Staff Member Initials _____ Date_____