Stonebrook Dental Care
Personalized & Comfortable

Stonebrook Dental

INSURANCE AND FINANCIAL POLICY

At Stonebrook Dental, we believe that you deserve the best care. That is why we always present you with the

Initial

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

_____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of packet figures you may require.

_____ We will bill your insurance as a courtesy. If insurance doe not pay within 60 days, Stonebroke Dental reserves the right to request payment in full for service from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charge incurred in our office.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a $75 cancellation fee (emergencies are an exception).

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_____ In the event, if you fail to appear for your appointment, you will be responsible for all the lab costs associated with your dental treatment. In addition, we will charge $100/hour (maximum 3 hours) for the time spend during the above mentioned dental work.

_____ In the event of an emergency after regular business hours, a $ 150 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $ 225 after hour's emergency fee.

_____ Patients will be responsible for any additional charges associated with their debt & past due balances after 60 days e.g. Collection agency's fees/charges.

_____ Patients will be charged $ 50 for requesting dental records & X-rays electronically or via regular mail.

I understand an agree with the above conditions.

PRINT NAME:

_____

DATE:_____

Patient/Parent Signature:

_____

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Patient Acknowledgement of Receipt of Dental Material Fact sheet

I, (Patient Name) _____, acknowledge I have received from STONEBROOK DENTAL a copy of the Dental Materials Fact Sheet published by Dental Board of California

_____ _____

Patient Signature Date

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of our notice of Privacy Practices or to document our good faith to obtain that acknowledgement.

Notice of privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices .We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient after April 14, 2003. We must make good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Therefore, we must distribute the Notice to each new patient at the time of service an to any person requesting a Notice. WE must also post the revised Notice in our office as discussed above.

_____

Patient Signature

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Smile Analysis

1. Do you love the way your smile looks? ☐ Yes ☐ No
2. Do you feel comfortable showing your teeth when you laugh or smile? ☐ Yes ☐ No
3. If you could change anything about your smile, it would be (check all that apply):
   - ☐ Color of your teeth
   - ☐ Too much or too little of teeth show when you smile
   - ☐ Gaps between your teeth
   - ☐ Size/Shape of your teeth
   - ☐ Too much or too little of gum shows when you smile
   - ☐ Alignment of your teeth
   - ☐ Other:_____
4. Do you have (check all that apply):
   - ☐ Sensitive or receding gums
   - ☐ Worn/broken/chipped teeth
   - ☐ Old or discolored fillings
   - ☐ Missing teeth
   - ☐ Old crowns that have dark edges at the top
   - ☐ Other:_____
5. In your line of work or lifestyle, do you (check all that apply):
   - ☐ Visit businesses or Clients
   - ☐ Travel
   - ☐ Speak publicly
   - ☐ Other:_____
6. If you had a smile makeover do you think you'd feel (check all that apply):
   - ☐ More confident
   - ☐ More optimistic
   - ☐ Healthier
   - ☐ Just OK
   - ☐ No different
   - ☐ Other:_____
7. Do you or someone in your family have issues with any of the following (check all that apply):
   - ☐ Chronic bad breath
   - ☐ Grinding teeth
   - ☐ Snoring
   - ☐ Other:_____

Photo Release

I authorize Dr. Kalpesh Patel DDS to take photographs, slides and /or video of my face, jaw and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and my be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone book, television), and professional publication (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name and other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the used of these photographs.

Signature _____ Date_____