Valley Dental

FAMILY DENTISTRY, ORTHODONTICS, & ENDODONTICS

Financial Policy

Welcome and thank you for choosing Valley Dental for your dental needs. You have chosen a family dental practice that is committed to providing you with excellent care and services. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

In order to keep the cost of dental treatment to a minimum we require payment at the time of service. We accept cash, checks (after the first visit). Visa/Mastercard/Discover and American Express. We also offer an extended payment plan called Care Credit. Ask the receptionist for details.

REGARDING INSURANCE
We may accept assignment of insurance benefits, if you can provide us with a dental card or a dental form. It is not possible to bill the insurance without this information. Your co-payment must be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We can only estimate your co-payments. It is your responsibility to keep a record of how much of your benefits have been used to prevent going over your annual maximum allowed. If the insurance does not pay their portion within 60 days, that balance is your responsibility.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS
Minors must be accompanied by a parent or guardian who is responsible for payment and treatment decisions. For unaccompanied minors, treatment will be deferred until a parent or guardian is present.

MISSED APPOINTMENTS
If you cannot keep your appointment we require at least 24 hours notice for appointments less than 40 minutes long and 48 hours notice for appointments 40 minutes or longer. Our policy is to charge for missed appointments if you do not notify us within ample time. Our current rate for a broken appointment is $24.00 for each 10-minute block of time. Please help us better serve everyone by keeping scheduled appointments.

Thank you for choosing our office. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy's conditions.

X_____ DATE_____

Signature of Patient or Responsible Party

Valley Dental

FAMILY DENTISTRY, ORTHODONTICS, & ENDODONT1CS

1655 Boston Rd
Springfield, Ma 01129-1130
(413)543-2101 Phone
(413)543-2104 Fax

www.valleydentaleastfield.com

General Consent for Dental Treatment

I understand the purpose of this general consent is to raise awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate (for example: root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges and dentures) to provide me with more specific consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to treatment. Of course, one alternative for me is to do nothing, although that carries with it its' own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity. For routine fillings, dental cleanings, prescriptions of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases, patients have had an allergic reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always risk of a post operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact Valley Dental as soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment of surgery.

I have the right to ask Valley Dental for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of procedures, and my alternative to the procedure.

_____ _____

Patient/Guardian Signature Date

Valley Dental

FAMILY DENTISTRY, ORTHODONTICS, & ENDODONT1CS

Name_____Home Phone(___)_____Cell Phone(___)_____
Address_____City/State_____Zip Code_____
Work Phone(___)_____ Height_____ Weight_____ Date of Birth___/___/_____M ☐ F ☐
Emergency Contact_____Relationship_____Phone(___)_____
If you are completing this form for another person, what is your name and relationship to that person?_____

For the following questions please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes No Unsure
☐ ☐ ☐ Do your gums bleed when you brush?
☐ ☐ ☐ Are your teeth sensitive to cold, hot, sweets, or pressure?
☐ ☐ ☐ Have you had any periodontal (gum) treatments?
☐ ☐ ☐ Have you ever had a serious/difficult problem associated with any previous dental treatment? If so, explain_____

Yes No Unsure
☐ ☐ ☐ Have you ever had orthodontic treatment?
☐ ☐ ☐ Do you have headaches, earaches, or neck pain?
☐ ☐ ☐ Do you wear removable dental appliances?

How would you describe your current dental problem?_____
Date of last dental visit?_____Date of last dental x-rays?_____
What was done at that time?_____
How do you feel about the appearance of your teeth?_____

Medical Information

Yes No Unsure
☐ ☐ ☐ Are you in good health?
☐ ☐ ☐ Has there been any change in your general health within the past year?_____

Do you have any of the following diseases or problems? If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.
☐ ☐ ☐ Active Tuberculosis
☐ ☐ ☐ Persistent cough greater than a 3 week duration
☐ ☐ ☐ Cough that produces blood

☐ ☐ ☐ Are you now under the care of a physician? If so, what is/are the condition(s) being treated?_____
Physician(s)_____Phone_____City/State_____
☐ ☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, explain?_____
☐ ☐ ☐ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, which one(s) are you taking? Prescribed_____
Over the counter, natural or herbal preparations_____
☐ ☐ ☐ Are you taking or have you taken any diet drugs such as Pondimin(fendluramine), Redux (desphenfluramine) or Phen-fen (phentermine)?
☐ ☐ ☐ Do you drink alcoholic beverages? If yes, how much in the last 24 hours?_____ In the past month?_____
If yes,_____# of drinks per day for_____# years.
☐ ☐ ☐ Are you alcohol and/or drug dependent? If so, have you received treatment? Yes ☐ No ☐
☐ ☐ ☐ Do you use drugs or other substances for recreational purposes? If yes, please list_____
Frequency of use (daily, weekly, etc.)_____Number of years of recreational drug use_____
☐ ☐ ☐ Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? ☐Very ☐Somewhat ☐Not interested
☐ ☐ ☐ Do you wear contact lenses?

Please see next page

Allergies: Are you allergic to or have you had a reaction to: (please fill out both columns)

Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food(specify)
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other(specify)

To yes responses please specify type of reaction_____

(Women Only)

☐ ☐ ☐ Are you pregnant?
☐ ☐ ☐ Nursing?
☐ ☐ ☐ Taking birth control pills?

Please *(X)* whichever applies to you: (Please note there are 3 columns')

☐ ☐ ☐ Have you had an orthopedic total joint(hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
☐ ☐ ☐ Have you had any complications or difficulties with your prosthetic joint?
☐ ☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
If so, what antibiotic and dose?_____Name of physician or dentist_____Phone_____

Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Abdominal Bleeding	☐	☐	☐	Disease,drug or radiation induced immunosupression
☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Diabetes
☐	☐	☐	Anemia				☐ Type 1
☐	☐	☐	Arthritis				☐ Type 2
☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	Dry mouth
☐	☐	☐	Asthma	☐	☐	☐	Eating disorder
☐	☐	☐	Blood Transfusion				If yes specify _____
			If yes, date _____	☐	☐	☐	Epilepsy
☐	☐	☐	Cancer/chemotherapy/ radiation treatment	☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Cardiovascular disease	☐	☐	☐	Gastrointestinal reflux
			If yes, specify below	☐	☐	☐	Glaucoma
			☐ Angina	☐	☐	☐	Hemophilia
			☐ Arteriosclerosis	☐	☐	☐	Hepatitis, jaundice, liver disease
			☐ Artificial heart valves	☐	☐	☐	Recurrent infections
			☐ Coronary insufficiency				Indicate type infection
			☐ Coronary occlusion				_____
			☐ Damaged heart valves	☐	☐	☐	Kidney problems
			☐ Heart attack	☐	☐	☐	Low blood pressure
			☐ Heart murmur	☐	☐	☐	Mental health disorders
			☐ High blood pressure				If yes specify _____
			☐ Inborn heart defects				_____
			☐ Mitral valve prolapse				_____
			☐ Pacemaker				
			☐ Rheumatic heart disease				
☐	☐	☐	Chest pain upon exertion	☐	☐	☐	Malnutrition
☐	☐	☐	Chronic pain	☐	☐	☐	Migraines
☐	☐	☐	Persistent diarrhea	☐	☐	☐	Night sweats

Yes	No	Unsure	
☐	☐	☐	Neurological disorders
			If yes specify _____
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems
			If yes specify
			☐ Emphysema
			☐ Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about?
			_____
			_____
			_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

*X*_____
Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history _____
_____
Significant findings from questionnaire or oral interview _____
_____
Dental management considerations_____
_____
Signature of Dentist
Health History Update: on a regular basis the patient should be questioned about any medical history changes, date and comments notated.

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Patient Information

Welcome

Patient Name:_____Date:_____
Street Address_____City/State_____
Zip Code_____Home Phone_____Cell Phone_____
Work Phone_____Email Address_____
Preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Cell Phone
Date of Birth_____SS#_____
Employer_____Address_____
If patient is a full-time student, name of school_____
Drivers License State & Number_____
Whom may we thank for referring you?_____

Primary Dental Insurance

Policy Holder_____Relation_____DOB_____
Address (if different)_____
Policy Holders Employer_____Insurance Co_____
Subscriber #_____Group #_____
Insurance Co Address_____City/State_____
Zip Code_____Phone #_____

Secondary Dental Insurance

Policy Holder_____Relation_____DOB_____
Address (if different)_____
Policy Holders Employer_____Insurance Co_____
Subscriber #_____Group #_____
Insurance Co Address_____City/ State_____
Zip Code_____Phone #_____

Signature:_____ Date: _____

Valley Dental, P.C.

M.L.Z., L.L.C 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 this 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 this Notice while it is in effect. This Notice takes effect (01/01/04), 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. 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 contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare 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 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 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 a 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 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 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 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 reasonably 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 authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose 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 get 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 cannot 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.____for each page, $___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 instances 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 not 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 how payments will be handled 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 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: Michael L Zepf_____

Telephone: (413) 543-2101_____ *Fax:* (413) 543-2104_____

E-mail: _____

Address: 1655 Boston Rd. Springfield. MA 01129

Valley Dental

FAMILY DENTISTRY, ORTHODONTICS, & ENDODONTICS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____

A copy of the Privacy Practice Policy is available upon request at any time in the office

IMPORTANT!!

You have a special insurance plan with a unique fee arrangement. We are pleased to serve your dental needs and this by no means reflects on the quality of your care, or treatment. The quality of care at Valley Dental will never be compromised. However because of the uniqueness of the discounted fee arrangement it is imperative that the appointment and financial guidelines be followed.

Be aware that if you cannot keep your appointment we require at least 24 hours notice, 48 hours notice for appointments over 40 minutes long. Our policy is to charge for missed appointments if you do not notify us within ample time. Our current rate for a broken appointment is $24.00 for each 10-minute block of time. Please help us better serve everyone by keeping scheduled appointments.

In addition all co-payments must be made at the time of service or your fee arrangement cannot be honored. Your fee arrangement in the current market place makes this a necessity if we are to continue to offer the highest quality of care and treatment possible.

I have read and understand this agreement,

X_____ Date_____

Signature of patient or responsible party