GREENLAKE FAMILY DENTISTRY

greenlakefamilydentistry@outlook.com greenlakefamilydentistry.biz

4230 Stone Way N • Seattle, WA 98103-7432 (206)633-3686

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

If married, please list your spouse's name:

_____

_____

Please list the name and phone number of your employer:

_____

_____

Whom may we thank for referring you to our practice?

_____

_____

In an emergency who should be notified? Please enter Name and Phone number below: *

_____

_____

Responsible Party Information:

If insurance subscriber is someone other than the patient, fill in below:

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ____ _____

Last First MI Preferred Name

Primary Dental Insurance:

Fill in insurance information where necessary:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Do you have Secondary Dental Insurance? ◯ Yes ◯ No

If yes, please notify the Front Desk of additional coverage information.

Consent for Services and Financial Policy

Financial Responsibility
New patients must arrive at their scheduled appointment with their insurance card, photo ID and insurance copay if applicable. Co-pays required by a patients insurance plan must be paid at the time of appointment. A $10.00 service fee may be applied when the copay is not paid at the time of the appointment. This fee is in addition to the copay amount owed. If there is a balance remaining after all insurance payments have been received the patient is responsible for payment and will be billed. Patient balances must be paid in full within 30 days of receipt of the patient's statement.

Greenlake Family Dentistry participates in several insurance plans. GFD is participating provider with most Delta Dental, Regence and Premera plans. If the patient has an insurance plan that GFD does not participate in, a claim will still be filed to your insurance as a courtesy. The patient is ultimately responsible for all charges associated with their dental care, regardless of insurance coverage.

If the patient does not have insurance coverage, please be prepared to pay in full at the time of service. Greenlake Family Dentistry does not extend credit. Financial arrangements may be made ahead of time if out of the office financing is needed.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Financial Policy.**

Treatment of Minors

Treatment of a Minor (under age of 18)
If a patient is a minor (or under the age of 18) a parent/guardian of the child must be present at the time new patient appointment. No exceptions. The parent is responsible to ensure payment of patient co-pay due at the time of service. GFD must have signed consent on file or a note signed by the parent/guardian if they do not accompany the minor to their appointments.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Consent for Treatment of Minors.**

Appointment Policy

Late Cancellation, No Show Fee Policy
A LATE CANCELLATION or NO SHOW FEE of $100.00 per hour will be charged to all patients who do not provide 48 hour notification to cancel a scheduled appointment. The charge will also apply to patients who miss or "no show" for their scheduled appointment. If a patient late cancels or no shows an appointment three times within a 12 month period, we reserve the right to schedule same day only appointments or terminate the doctor-patient relationship.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Appointment Policy.**

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

Protecting your Healthcare Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues related to your treatment, payment and our healthcare operations. Your personal health information will never be otherwise given or disclosed to anyone - even family members - without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentially, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)
We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raisings purposes without your written consent. We may use and/or messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Your Rights as our Patient
You have a right to request copies of your healthcare information, to request copies in a variety of formats, and to request a list of instances in which we, or our business associates, have disclosed your PHI for uses other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

HIPAA Acknowledgement

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Greenlake Family Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Greenlake Family Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below.

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____