The Dental Studio, LLC©
Modern Dentistry, Affordable Price

Welcome!

We're glad you're here. We know that going to the dentist may not be at the top of your "to do" list. But whether it's been six months or six years since your last visit, we're just glad you're here. We promise to listen to your hopes and fears, jitters and concerns. To provide care without pressure, and advice without obligation. To deliver equal doses of care and honesty, because we're confident you'll trust us with your mouth when you know we have your best interests at heart. And we'll stop at nothing to deliver an experience that is above and beyond what you thought dental care could be.

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Receipt of Treatment Plan & Financial Policies

*Retain Original in Patient's Chart

1. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients). By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

X Signature_____Date_____ (If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

2. Notice of Privacy Practices (must be signed by ALL new patients). By signing below, I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

X Signature_____Date_____ (If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance). To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities about my insurance claim. This information will be used exclusively for evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

X Signature_____Date_____ (If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

(Continue to the back side)

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4. <u>Consent to obtain patient medication history</u>. To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

X Signature_____Date_____ (If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

5. Appointment Policy. I, the undersigned, recognize that I have received a copy of the Appointment Policy and agree to abide by its protocol. I agree that if I cannot, specific actions will be taken.

X Signature_____Date_____ (If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled) Circle One: Dr. / Mr. / Mrs. / Ms. / Miss

First: _____ Middle: _____ Last: _____ Jr/Sr:_____

Street: _____ City: _____ State: _____

Zip: _____ Preferred Gender:(circle) Male | Female

Phone Number:

Home Phone: (____) _____

Cell Phone:(____) _____

Patient SSN: _____-_____-_____ Patient Date of Birth: _____/_____/_____

Signature: _____Date:_____

Financial Policies

At the Dental Studio practice, we are committed to giving you exceptional service and providing treatment that addresses both your short-term and long-term needs. We make it easier for you to get the care you need with our Peace of Mind Promise, which includes a commitment to everyday low fees, flexible financing options, and no surprises. We also accept a variety of payment options and will work with all insurers. We're committed to keeping our fees low so that you can get the care you need. We know you have a choice, and we appreciate your decision to trust us with your dental care.

1. A Clear, Written Estimate on the Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate on the cost of your treatment plan in writing, so you know what to expect, including your estimated insurance benefits. If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

2. Payment Policy The following payment policies apply:

• Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment Acceptance and Payment Arrangement Form, is due no later than when services are rendered. Acceptable forms of payment include cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits and select third-party financing programs. INCLUDES CO-PAYS.

• For comprehensive treatment plans requiring multiple office visits, a minimum deposit of two-thirds (2/3) of the Patient Financial Responsibility amount is required and will be discussed between the patient and Patient Financial Representative.

• You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans. Refunds will be processed in accordance with our refund policy. Additional discounts may be applied to treatment plans paid in full, but are not guaranteed and added at The Dental Studio, LLC discretion. No

discounts are guaranteed and require certain requirements that will be brought to attention by the Patient Financial Representative to the Patient. The Dental Studio, LLC has the right to revoke or modify any discount at any time.

3. Refund Policy

You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive; provided, however, crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun. It is the patient's responsibility for notifying The Dental Studio, LLC of any changes regarding the patient's account. Includes but not limited to change of address, phone number and insurance policy.

Your refund request will be handled as follows:

- Once the Dental Studio receives a written request for refund, you will receive a check in the mail 6-8 weeks after the request has been reviewed and approved.

4. Dental Insurance

If you have dental insurance, your insurance claim will be processed as follows:

- **In Network**: If your dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist's agreement with your insurer.
- **Out of Network**: If your dentist is not a participating or in-network provider with your insurance plan, we will honor your carriers in network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.
- **Insurance Discounts:** Insurance companies often negotiate discounts for services provided to their plan members. Should you exceed your annual benefit limit, the insurers discounted rate may apply to additional services as a benefit to you. The Dental Studio practices will honor your insurer's policy.

5. Third-Party Financing Disclosure

The Dental Studio practice accepts payment from non-affiliated, third-party finance companies (i.e., CareCredit issued by Synchrony Bank)The practice pays these companies fees on a sliding scale for making financing available to patients like you and for the finance companies cost of servicing these

loans. As the aggregate amount of care financed through these finance companies increases, the fees they charge the Dental Studio practices decrease. This sliding scale pricing arrangement does not affect the amount you finance or the cost of your treatment. Credit decisions are solely the responsibility of these third-party finance companies. You may elect to pay all or a portion of your treatment using one of these third-party financing products.

APPOINTMENT POLICY

Please be sure to read our entire outlined Appointment Policy in your Patient Folder)

We enforce a very strict appointment policy. When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please **provide us with at least 24 hours' notice**. *This courtesy makes it possible*

to give your reserved time slot to another patient who would be more than happy to accept. We understand there are uncontrollable circumstances and will be handled on a per incident basis.

***Repeated cancellations (limit 2) or missed appointments (limit 2) will result in loss of future "scheduled patient" status appointment privileges for no less than 6 months.**

Every patient in our practice receives this unique reservation. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you

I authorize the disclosure of information from my treatment records to:

Name of Recipient:

_____

Relationship to the Patient:

_____

I give authorization to disclose the following information: All treatment information specifically related to these treatment dates:

Starting Date: _____ End Date: _____ or Indefinite

(please circle if you chose the indefinite option)

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying the Dental Studio, LLC practice in writing.

X Signature of Patient (or Patient Representative) _____

Printed Name of Patient (or Patient Representative)

_____ Date: _____

GENERAL CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

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Patient Date of Birth: _____

1. I authorize the performance of a dental examination and evaluation, possibly including radiographs as approved by the faculty member(s) of the Dental Studio.

2. I understand that the services will be provided by an assigned provider at the Dental Studio.

3. I understand photographs may and will be taken for treatment and identification purposes only.

4. I understand that the treatment received, information about the care will be shared by clinical staff.

5. I further understand other employees may also provide services consistent with the treatment plan. When, in the opinion of the clinic, a change of provider is deemed appropriate, the change is made at the clinic's discretion.

6. I have received a copy of the fee policies for the Dental Studio. I understand and agree to comply with those policies.

7. I have received a copy of the Stony Brook Organized Health Care Arrangement Joint Notice of Privacy Practices. I authorize the use and disclosure of my health information to treat me and arrange for my care, to seek and receive payment for services given to me, to send appointment reminders via mail or phone, and for the business operations of the Dental School and its staff.

8. I have received a copy of the Patient Bill of Rights.

9. Any questions I have had to the above have been fully answered.

10. I fully understand the conditions of this consent and have no additional questions.

11. All policies and copies of paperwork (if requested) will be given to me in a personalized patient folder for me to take home.

X Authorized Signature: _____ Date: _____

Relationship to Patient, if signing on behalf of a minor: _____