

Dr. Jerrold  
**G O L D S M I T H** DDS  
*Experience | Compassionate Care | Exceptional Service*

Dear New Patient,

On behalf of the staff team members here at Dental Health Associates, I want to thank you for the opportunity to serve your dental needs. Our philosophy of care is simple; we take the trust you place in us very seriously, and value each and every patient we serve. Below are our core values that reflect our commitment to quality care.

***Extensive Experience:*** We have provided over 30 years of experience backed with a highly skilled staff and advanced, proven technologies.

***Compassionate Care:*** We care, we listen, we address your needs, and we deliver prompt and effective solutions.

***Exceptional Service:*** We believe in quality customer service; always addressing your needs and welcoming any suggestions or concerns.

Please take the time to read and fill out the following forms so that my team and I can give you the most accurate dental health examination.

We sincerely welcome you to our patient family!

Sincerely,



Dr. Jerrold Goldsmith and Staff

## **NEW OFFICE POLICIES INFORMATION (IMPORTANT - PLEASE READ)**

### **FINANCIAL POLICY:**

We warmly welcome you to our dental office, and we promise to do everything in our power to make your dental experience as pleasant and comfortable as possible. Initial visits (whether an emergency or a comprehensive exam), give us the opportunity to offer a professional relationship with you and your family. Until credit and/or insurance verification and benefits can be confirmed, you will be expected to pay for your first visit. We accept cash, credit/debit cards, or personal checks. Once all necessary information is received we offer several methods of future payment.

**IF YOU DO NOT HAVE INSURANCE:** We will establish a mutually agreed upon course of treatment along with the cost, time, and number of visits needed to complete. Payment can be as follows:

1. Payment in advance we offer a 5% discount on full treatment of \$1000.00 or more, if you are over 65 and pay in advance, receive an additional 2%.
2. Total may be paid in up to 4 equal installments not to exceed 120 days (dependent on treatment). Financial coordinator will assist.
3. Budget – Establish an amount and frequency you wish to pay into a credit balance and we can then coordinate the credit amount with the amount needed for the future visits.
4. We have 3 great outside payment options for amounts over \$750.00. For example, if your total is \$3800 you can, if you elect, pay monthly amounts that fit your budget easier.

**IF YOU DO HAVE INSURANCE:** You may select (1) and be reimbursed directly by your insurance company. You may select (2) and we will collect from the insurance company and you pay your estimated share in 3 to 4 payments. You may select (3) if desired, for your estimated patient liability portion.

**REDUCED FEE DENTAL PLANS WITHOUT INSURANCE BENEFITS:** We do accept some REDUCED FEE dental plans. We gladly provide quality service to you at the reduced fees. Full payment for needed and agreed upon services in your treatment plan are paid prior to your appointment.

Payment accepted by credit/debit card, check or cash. If extended payments are necessary, we recommend any one of the 3 outside dental financing companies.

**REDUCED FEE DENTAL PLANS WITH INSURANCE BENEFITS:** Same as above with the following additions:

- a) You will be reimbursed, by your insurance company, as care is completed.
- b) Those needing major care (i.e. crown, root canal, denture and bridgework), arrangements can be made for payment in 2 installments.

### **APPOINTMENT CANCELLATION POLICY:**

We are keenly aware of our patients' busy schedules and are committed to making your visit as comfortable and time-efficient as possible. Please consider that when you schedule an appointment with us, an agreement is being made: **we commit** to reserving a specified amount of time for you so that we may care for your dental needs. Likewise, **you commit** to being present at the agreed upon time. Breaking this agreement impacts the dentist, the office staff, and other patients who wish to schedule with the dentist or hygienist in a timely manner.

As a courtesy to you, we send an appointment reminder card 10-14 days in advance of your Hygiene appointment. In addition, we attempt to confirm your appointment by phone 48 hours in advance. **We realize that unforeseen events do occur. However, if your appointment is not cancelled with at least a 48 hour business day notice (Monday–Thursday), expect to incur a charge of:**

- \$50.00 for appointments that are scheduled to last up to an hour
- \$100.00 for appointments that are scheduled over an hour

### **CONSENT FOR SERVICES:**

**AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, I UNDERSTAND THAT PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED. I MAY PAY WITH CASH, PERSONAL CHECK (WITH APPROVAL), VISA, MASTERCARD, DISCOVER OR DEBIT CARD. I UNDERSTAND THAT ALL EMERGENCY DENTAL SERVICES OR ANY SERVICES PERFORMED AFTER REGULAR BUSINESS HOURS MUST BE PAID IN CASH AT THE TIME SERVICES ARE RENDERED.**

**A SERVICE CHARGE OF 1.5% PER MONTH (18% PER ANNUM) ON THE UNPAID BALANCE WILL BE CHARGED ON ALL ACCOUNTS AGED 30 DAYS, REGARDLESS OF PENDING INSURANCE.**

**I UNDERSTAND THAT THIS OFFICE HAS THE RIGHT TO CHARGE ME FOR A FAILURE TO KEEP A RESERVED APPOINTMENT OR FOR CANCELING AN APPOINTMENT WITHOUT 24 HOUR BUSINESS DAYS ADVANCED NOTICE.**

**NEW OFFICE POLICIES INFORMATION (CONTINUED)**

I UNDERSTAND THAT THE FEE ESTIMATE GIVEN TO ME FOR ANY DENTAL CARE IS ONLY AN ESTIMATE AND CAN ONLY BE EXTENDED FOR A PERIOD OF SIX MONTHS FROM THE DATE OF THE PATIENT EXAMINATION. I ALSO UNDERSTAND THAT DUE TO THE NATURE OF DENTAL CARE AND THE UNFORESEEN PROBLEMS THAT MAY ARISE DURING TREATMENT, FEES AND/OR TREATMENT MAY CHANGE.

IN THE EVENT THAT MY ACCOUNT BECOMES DELINQUENT, I UNDERSTAND THAT FUTURE TREATMENT WILL BE DELAYED UNTIL THE BALANCE HAS BEEN PAID. I ALSO UNDERSTAND THAT IF MY ACCOUNT BECOMES DELINQUENT, I SHALL BE RESPONSIBLE FOR ATTORNEY FEES, COLLECTION AGENCY FEES, COSTS OF COLLECTIONS, COURT COSTS, AND/OR OTHER EXPENSES AND FEES IF NECESSARY.

I AUTHORIZE PAYMENT OF DENTAL BENEFITS, OTHERWISE PAYABLE TO ME, DIRECTLY TO DR. JERROLD GOLDSMITH.

I GRANT MY PERMISSION TO YOU OR YOUR ASSIGNEE, TO TELEPHONE ME AT HOME OR WORK TO DISCUSS MATTERS RELATED TO THIS FORM. I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

I UNDERSTAND THAT I MAY INCUR BANK SERVICE AND INTEREST CHARGES AS WELL AS DR. GOLDSMITH OFFICE ADMINISTRATIVE FEES IN THE EVENT I ELECT TO CANCEL SERVICES TO BE PERFORMED AT DR. GOLDSMITH'S OFFICE AFTER I HAVE OBTAINED CREDIT THEREFORE.

**I HAVE READ, FULLY UNDERSTAND, AND AGREED TO DR. GOLDSMITH'S REVISED FINANCIAL POLICY, APPOINTMENT CANCELLATION POLICY, AND CONSENT FOR SERVICES, PER THE SIGNATURE BELOW.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2011  
*Last First MI*

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2011

Home #: (\_\_\_\_) - \_\_\_\_\_ Cell #: (\_\_\_\_) - \_\_\_\_\_

Work #: (\_\_\_\_) - \_\_\_\_\_ Ext #: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2011

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**PATIENT INFORMATION (PLEASE PRINT)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2011  
*Last First MI*

Check all that Apply: Male  | Female  | Single  | Married  | Child

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
*Street Apartment #*

\_\_\_\_\_  
*City State Zip Code*

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext #: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

[  ] YES! Please Sign Me up for Dr. Goldsmith's Free Email Newsletter

Spouse Name: \_\_\_\_\_

Spouse Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street Suite*

\_\_\_\_\_  
*City State Zip Code*

Person to Contact in Case of Emergency: \_\_\_\_\_  
*(Nearest Relative/Friend not Living with You)*

Contact Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**PLEASE FILL OUR THIS FORM ENTIRELY. THANK YOU!**

**PATIENT HEALTH INFORMATION (PLEASE PRINT)**

Date of Last Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason for Visit: \_\_\_\_\_

Have you ever had any of the following? (*Please check all that apply*)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Pacemaker               |
| <b>Allergies:</b>                            | <input type="checkbox"/> Tumor                | <input type="checkbox"/> Pregnant                |
| <input type="checkbox"/> Latex               | <input type="checkbox"/> Diabetes             | Due: ____ / ____ / ____                          |
| <input type="checkbox"/> Penicillin          | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> <b>PRE-MED</b>          |
| <input type="checkbox"/> Sulfa               | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> Codeine             | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Respiratory Problems    |
| <input type="checkbox"/> Kiwi                | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Bananas             | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Chestnuts           | <input type="checkbox"/> <b>Heart / MVP</b>   | <input type="checkbox"/> Skin Rashes/Hives       |
| <input type="checkbox"/> Avocado             | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Smoke                   |
| <b>Other:</b>                                | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Spina Bifida            |
| <input type="checkbox"/> _____               | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Stomach Problems        |
| <input type="checkbox"/> _____               | <input type="checkbox"/> Herpes               | <input type="checkbox"/> Stomach Ulcers          |
| <input type="checkbox"/> _____               | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Anemia / Hemophilia | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> TMJ / Jaw or Joint Pain |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Other:                  |

Have you ever had any complications following dental treatment?

- Yes    No   *If yes, please explain:* \_\_\_\_\_

Are you currently taking any drugs or medications?

- Yes    No   *If yes, please explain:* \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?

- Yes    No   *If yes, please explain:* \_\_\_\_\_

Are you now under the care of a physician?

- Yes    No   *If yes, please explain:* \_\_\_\_\_ *Physician Name:* \_\_\_\_\_

Do you have any health problems that need further clarification?

- Yes    No   *If yes, please explain:* \_\_\_\_\_

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2011  
*Patient, Parent, or Guardian*

**NOTICE OF PRIVACY PRACTICES (IMPORTANT – PLEASE KEEP)**

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.

**The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”)** is a federal law that requires us to maintain the privacy of your health information. We are also required to inform you as to how we may use or disclose your dental health records and other individually identifiable health information. This Act also gives you, the patient, certain rights regarding how your health information is used. This notice takes effect immediately and will remain in effect until we replace it. Any changes made to this policy will be made available to you.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you only for treatment, payment, and healthcare operations.

- **Treatment** means that we may use or disclose your health information to another dentist, physician or other healthcare provider in order to provide treatment to you.
- **Payment** means activities such as obtaining payment or reimbursement for services we provide, confirming insurance coverage and coordination of benefits, electronic submission of claims and billing or collection activities.
- **Healthcare Operations** include the business aspect of running our practice such as providing recall and appointment reminders, phone confirmation of appointments, information about treatment alternatives or other health-related benefits and services that may be of interest to you. This may also include in-office practice management analysis and quality assessment review.
- **Exceptions:** In the event of your incapacity or other emergency circumstances, we may disclose relevant health information, based on our professional judgment, in order to provide you with adequate healthcare. We may use or disclose your health information when required to do so by Federal or State law, for example: in cases of Public Health concerning certain communicable diseases such as Smallpox; in the reasonable belief of cases of possible abuse, neglect or domestic violence, to avert a serious threat to your health and safety or that of others; and, in certain circumstances, to authorized Federal or State Law Enforcement Officials.
- **Your Authorization:** Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing at any time and we are required to abide by that **written request**, except where we have already taken actions because of your previous consent.

**PATIENT RIGHTS**

You, the patient, have the following rights with respect to your protected health information, which you can exercise by presenting a **written request** to our office Privacy Officer.

- **Access:** You have the right to inspect and receive copies of your health information. You have the right to request that we disclose your information to a family member, friend or personal representative who is responsible for your healthcare or with payment for your healthcare.
- **Disclosure Accounting:** You have the right to receive a list of instances in which we have disclosed your protected health information for purposes, other than treatment, payment or healthcare operations.
- **Restriction:** You have the right to request restrictions on certain uses or disclosures of health information. We are, however, not required to agree to these, but if we do, we will abide by alternative means or at alternative locations.
- **Alternative Communication:** You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- **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.
- **Notice:** You have the right to obtain a paper copy of this Notice from us upon request.
- **Protection:** If you feel that your privacy protections have been violated, you have the right to file a complaint with this office, or with the Department of Health and Human Services or the Office of Civil Rights.

AS ALWAYS, OUR COMMITMENT TO YOU, OUR PATIENT IS TO CONTINUE TO ACT IN YOUR BEST INTEREST AND TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL HEALTHCARE.

I, \_\_\_\_\_, **have received a copy of this office’s Notice of Privacy Practices.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / **2011**