Optimal Dental Center
The World Is Brighter When You Smile!

1801 Robert Fulton Drive
Suite 250
Reston, VA 20191
(703) 391-2222

8303 Arlington Blvd.
Suite 107
Fairfax, VA 22031
(703) 226-2222

CANCELLATION POLICY

Dear Patients,

If you are more than 15 minutes late without proper notice, you will be charged a $25.00 **LATE FEE** and may be asked to reschedule your appointment.

If you do not show up for your appointment and do not call us to reschedule **at least 48 hours prior** to your appointment, you will be responsible for a $25.00 (per hour of appointment) **NO SHOW FEE.**

The purpose of this agreement is to allow us to more completely serve you and to reduce your wait time.

I have read this policy and I understand and accept it.

_____

Patient's Name.

_____

Patient's Signature. *Date.*

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FINANCIAL POLICY WITH INSURANCE COVERAGE

Dear Patient,

We participate with most insurance policies, except HMOs. We will process your insurance claims but request that you pay your estimated portion at the time of service.

Although we do our best to gather your personal dental coverage information, we would like to inform you that it is impossible for our office to be completely familiar with a particular plan and/or insurance limitations. Your insurance is a contract between you, your employer, and the insurance company. As an outside party, our ability to obtain specific plan details is limited. Even though we will do our best to work alongside your insurance, it is impossible for our office to *guarantee* the benefits your insurance will provide.

I, _____, understand that my insurance is my personal responsibility. As a courtesy to our family, Optimal Dental Center's staff will assist us with insurance verification and an estimate of my benefits. Additionally, I understand that ANY AMOUNT NOT PAID BY INSURANCE COMPANY for ANY TREATMENT/SERVICES performed at Optimal Dental Center is my responsibility and that any remaining balance must be promptly paid to prevent further collection process.

ASSIGNMENT OF BENEFIT-MEDICAL INSURANCE if applicable

There are procedures in a dental office that might be payable by medical insurances hence releasing dental benefits to dental specific treatments. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **OPTIMAL DENTAL CENTER** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

_____ I understand the above information and have been given the opportunity to ask questions.

_____ _____

(Patient Signature) **(Date)**

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Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell phone: _____

Email Address: _____ May we contact you by email: ☐ Yes ☐ No

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ 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: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- List and dosage of medications currently taking: _____

To the best of my knowledge, all of the preceding 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 without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Insurance ☐ Google ☐ Social Media ☐ Another Dental Office ☐ Work ☐ Other_____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact

Name: _____ Relationship to Patient: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will assist in making collections from insurance companies and will credit any such collections to the patient's account. However, patients are ultimately responsible for any amount not paid by their insurance.

An interest charge of 18% per annum (1&1/2% per month), compounded monthly, on the unpaid balance will be charged on all accounts, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree to pay all costs and attorney fees in the amount of 35% of the principle amount owed, if my account is referred to an attorney for collection.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS IINFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment at Optimal Dental Center is to serve our customers with professionalism and care, being sure at all times to protect their privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

***During treatment we may find it necessary to acquire a laboratory analysis.**

***For payment purposes, we may use the services of a billing service.**

***During health care operations, we may need a second opinion.**

We here at Optimal Dental Center are committed to obeying all Federal State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

If you have any questions or comments regarding your Protected Health Information feel free to contact our Compliance Officer:

Dr. Trang Thanh N. Ton, D.C, L.Ac at (703) 391-2222 or (703) 226-2222

I have read and understand the above Notice of Privacy Practices.

Signature_____ Date_____
(Patient or Legal Guardian)