



Patient Registration Form

Personal Information

Patient's Name: _____

First Last

Gender: Male or Female (circle one) Nickname: _____

Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____

Referral Source: _____
(dentist, friend, physician, phonebook, internet)

Address/Contact Information

Address: _____

City: _____ Zip: _____

Home Phone: (_____) _____ - _____

Other Phone: (_____) _____ - _____

Other family members seen here: _____

Parents (or guardian): Single _____ Married _____ Divorced _____ Widowed _____

Mother's Name (or Legal Guardian): _____ DOB: ____/____/____ SS#: ____/____/____

First Last

Phone: _____ Employer: _____

Father's Name (or Legal Guardian): _____ DOB: ____/____/____ SS#: ____/____/____

First Last

Phone: _____ Employer: _____

Person Responsible for Account, if different from above

Guarantor's name: _____ SS#: _____ - _____ - _____

Address: _____

Number Street City State Zip

Phone #: (_____) _____ - _____ Alternate Phone #: (_____) _____ - _____

Relationship to Patient: _____

Insurance Information

Primary Insurance Name: _____ Secondary Insurance Name: _____

Group #: _____ I.D.# _____ Group #: _____ I.D.# _____

I authorize and request treatment from Dr. Hylton. I authorize the use of diagnostic aids, medications, patient photos, and procedures that are necessary in the professional judgment of Dr. Hylton. I authorize the release of information relating to my child's dental care for insurance purposes and authorize payment of the insurance benefits directly to Children's Dentistry of the Rockies for treatment performed on my child. I understand that as a courtesy, this office will bill my insurance carrier according to the information I have provided above. I further understand that my dental insurance is a contract between me and the insurance carrier, and that I am still fully responsible for the entire dental fee. I agree that I am financially responsible for the cost of treatment as well as any collection costs, court costs, attorney fees and any delinquent account fees. I understand that should my account become delinquent it could be subject to an 18% annual interest rate.

Parent/Legal Guardian: _____ **Date:** _____



APPOINTMENT POLICY

At each appointment a portion of the doctor and staffs time is reserved specifically for your child. Any change in this appointment may affect our ability to effectively treat other patients in a timely manner. If a cancellation is unavoidable, please call our office **AT LEAST 24 HOURS** in advance so that we may give that time to another patient. Should you arrive late for your appointment it may be necessary to reschedule.

- ✓ Most restorative procedures (fillings, extractions, etc.) and procedures requiring medication are scheduled in the morning. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- ✓ We strive to see all patients on time for their scheduled appointments. There are times when our schedule is delayed in order to accommodate a child with an urgent emergency. Please accept our apology in advance should this occur during your appointment.
- ✓ If 3 missed or cancelled appointments occur without 24-hours notice, we reserve the right to dismiss you from the practice or require a non-refundable deposit be made prior to scheduling.

FINANCIAL POLICY

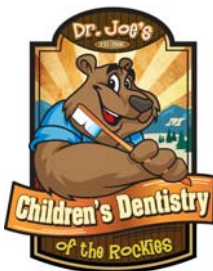
Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.*

- ✓ Please be aware that the parent bringing the child to Children's Dentistry of the Rockies is *legally responsible for payment of all charges.* We cannot send statements to other persons without written consent from the guarantor.
- ✓ **No Dental Insurance - Payment is expected in full for each appointment as services are rendered.** For the convenience of our patients, we accept cash, personal checks (which cannot be postdated), and credit cards. We also offer Care Credit as another financing option. Those who pay with CASH or CHECK in full at the time of service will receive 5% discount.
- ✓ **Dental Insurance** – The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. We will file your insurance claim as a benefit to you, however you are responsible for the full balance including any amount that is not paid by your insurance company. We require a 20% payment at time of service for all work rendered except preventative services. The remaining balance will be billed to your insurance.

Occasionally an outstanding balance may occur in which case we require it to be paid in full within 30 days unless other arrangements have been made. We will not schedule future appointments until the balance on the account is paid in full. We reserve the right to apply a billing charge of \$2.00 per month from the date of service. Should your account be sent to a collection agency a processing fee will be added to the balance. Thank you in advance for your understanding of our financial policy!

Parent/Legal Guardian

Date



HIPAA 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
INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care options and for all other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your dentist is ready for you to be seen. We may use or disclose your protected health information, as necessary, to contact you and to remind you of your upcoming appointments.

Required by Law

We may use or disclose patient health information when we are required to do so by law. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature:

Date:
