**Unique Smiles of McHenry**
4101 W Shamrock Lane, McHenry, IL 60050
(815) 385-0777
usmilesofmchenry.com/



# NEW PATIENT FORM (MINOR)

## Basic Information

| | | | |
|---|---|---|---|
| Name: | | Gender: | |
| Preferred Name: | | DOB: | |
| Referral source: | | School: | |
| Referred by: | | Special needs: | |

## Contact Information

| | |
|---|---|
| Mobile phone: | |
| Home phone: | |
| Email: | |
| | |

## Address Information

| | |
|---|---|
| Street address: | |
| City: | |
| State: | |
| ZIP: | |

## Parent/Guardian (Primary Contact)

| | |
|---|---|
| Full Name: | |
| Relation: | |
| DOB: | |
| Mobile phone: | |
| Email: | |
| Has legal custody: | |
| Employer: | |

## Parent/Guardian (Secondary)

| | |
|---|---|
| Full Name: | |
| NOT PROVIDED | |
| | |
| | |
| | |
| | |
| | |

## Parent/Guardian (Primary Contact)

| | |
|---|---|
| Home phone number | |

Patient's signature: Date:

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# CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Unique Smiles of McHenry and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Unique Smiles of McHenry of any changes in my child's medical status.

Patient's signature: Date:

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# PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization, or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 4101 W Shamrock Lane, McHenry, IL 60050

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment, or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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# FINANCIAL POLICY

Our goal is to provide the highest quality of dental care possible and to clearly communicate our financial policy.

I agree to be responsible for payment of all services rendered to myself and my dependents. I understand payment is due at the time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through the use of my Social Security number and any other information given.

**If I do choose to pay with a credit card, I am aware that there is a 3.75% charge on each transaction with this form of payment**. **I understand that there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date.** There is a $35.00 processing charge for insufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment, it will be turned over to an outside collection attorney**.** I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in order to collect payment due.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance claims on my behalf. I hereby authorize release of all information needed for such claims and also authorize my insurance company to pay directly to this office benefits accruing under my policy. **If the insurance company does not pay after 60 days, I agree to pay the full remaining balance.**

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine, and I am obligated and agree to pay the full remaining balance.

**Cancellation Policy:**

**Patients arriving more than 10 minutes late for an appointment may need to be rescheduled.**

**During Office Hours: Appointments must be rescheduled or canceled within 24 hours of scheduled appointment time to avoid a cancellation charge of $50.00.**

**After Office Hours: Appointment cancellation made on voicemail or email (NO TEXT) must be made within 48 hours to avoid a cancellation charge of $50.00.**

By signing this, I acknowledge the above conditions of treatment and payment and agree to these terms.

Patient's signature: Date:

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# COMMUNICATION CONSENTS

## EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Unique Smiles of McHenry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Unique Smiles of McHenry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Unique Smiles of McHenry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Unique Smiles of McHenry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Unique Smiles of McHenry.

Patient's signature: Date:

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## TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Unique Smiles of McHenry offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Unique Smiles of McHenry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Unique Smiles of McHenry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Unique Smiles of McHenry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Unique Smiles of McHenry.

Patient's signature: Date: