Emerald Dental - Littleton
2731 West Belleview Avenue, Littleton, CO 80123
(303) 630-0991
drstephaniepaswaters.com/contact-us/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Office Policies

Office Policies

We would like to make your visits as pleasant, comfortable and convenient as possible. The following will explain to you our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible.

APPOINTMENTS

The Doctor & Staff will make every effort to begin treatment at your appointed time; however, dental emergencies do occur. In this situation we do ask for your understanding. If this causes a problem with your schedule, please feel free to reschedule your appointment.

MISSED/CANCELLED APPOINTMENTS

Our policy is to **charge $60 per hour** for missed/late cancelled appointments unless a cancellation is received at least 48 hours in advance. Cancellations must be received during normal business hours and are not accepted via text message or email. Please help us serve you better by keeping your scheduled appointments.

SAME DAY EMERGENCIES

Two emergency slots per day (morning and afternoon) will be built into each day???s schedule. Additional emergency appointments may open up depending on schedule availability.

AFTER HOURS EMERGENCIES

If you are experiencing a true dental emergency outside of normal business hours, call us at **720-369-3182**. The emergency staff member will assess your situation and reach out to the Doctor if needed. A minimum fee of $25.00 will be charged for all telehealth calls, which may include the Doctor prescribing a medication for you. If your emergency requires an in-office emergency appointment, there will be an extra fee of $100.00 charged to the patient that must be paid that day using Cash, Check or Zelle.

WHAT TO EXPECT ON YOUR INITIAL VISIT

The initial visit is spent conducting a thorough examination, including x-rays, as needed, and a complete dental history. In those cases where emergency treatment is necessary for relief or prevention of pain, the complete evaluation is usually accomplished in the second office visit.

CHILDREN

We are happy to treat children of all ages and we recommend that a child have his/her first dental examination 6 months after they get their first tooth or by their first birthday. We do not institute dental treatments, other than preventive procedures, on your child???s first dental visit unless he/she is experiencing discomfort. An adult must accompany children at all times while in the reception area. In addition, we ask that adults do not bring unsupervised children to their dental appointments; specifically infants and toddlers.

If at any time you have questions regarding any treatment, fees or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, rectify an injustice, or to preserve a friendship.

I have read the policies and agree with the terms outlined above.

Patient's signature: Date:

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FINANCIAL POLICY

- All patients must complete our Patient Information Form prior to seeing the doctor.
- Full payment is expected at the time services are rendered unless other arrangements have been made in advance. **There will be a 0.25% monthly (3% annual) finance charge added to all payment arrangements or unpaid balances.**
- Payment arrangements can be made with approved credit by an independent financial institution.
- We accept Cash, Check, Zelle, Visa & Mastercard. **There will be a 2% transaction fee for all credit card payments.** (***A $25 processing fee will be applied to your account for any returned checks.)

Dental Insurance

- To avoid disappointment, we strongly suggest that patients contact their insurance company to make certain their dental assumptions are correct. Insurance companies pay only a portion of the dental investment. Further, patients must realize that professional services are rendered to a person, not to an insurance company. The insurance is responsible to the patient and the patient is responsible to us. For this reason, you are responsible for resolving disputes between you and your insurance company regarding deductibles, copayments, covered benefits, secondary coverage, ???Usual and Customary charges???, etc.
- In order to process dental claims properly and receive timely benefits, we must have:
- Insurance identification card
- Social Security Number of the policy holder
- Date of Birth of the policy holder
- We can ***estimate*** your coverage and benefits from your insurance plan, and the patient will be responsible for any deductibles and/or copayments at the time of service. Although our staff does their best to give you the most accurate estimates possible, they can be subject to change based on the final decision made by your insurance company. You will be responsible for any charges unpaid by your insurance. In addition, if your insurance has not paid the full balance within 60 days, we ask you to clear the balance in 15 days.
- In the unfortunate event of non-payment for services rendered, any balance due on an account will be forwarded to an outside agency I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs.
- If at any time you have questions regarding any treatment, fees or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, rectify an injustice, or to preserve a friendship.
- ***I have read the policies and agree with the terms outlined above.***

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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. Emerald Dental - Littleton 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. Emerald Dental - Littleton will use reasonable means to protect the security and confidentiality of email information sent and received. However, Emerald Dental - Littleton 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 Emerald Dental - Littleton and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Emerald Dental - Littleton.

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. Emerald Dental - Littleton, 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. Emerald Dental - Littleton will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Emerald Dental - Littleton 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 Emerald Dental - Littleton and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Emerald Dental - Littleton.

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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: 2731 West Belleview Avenue, Littleton, CO 80123: 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: