Bella Smile Dentistry
2720 SW 97th Ave #101 # 101, Miami, FL 33165
(786) 534-6920
www.bellasmiledentistry.com/

NEW PATIENT FORM

Basic Information

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

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Pharmacy Information

Pharmacy Name	
Pharmacy Full Address (Street, City, State, Zip):	

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: 2720 SW 97th Ave #101 # 101, Miami, FL 33165:

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.

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FINANCIAL POLICY

Thank you for choosing Bella Smile Dentistry as your dental care provider. We are committed to helping you achieve successful treatment and a positive experience. Please understand that payment for services is considered part of your treatment. The following financial policy is intended to promote clear communication and avoid misunderstandings so you can make informed decisions about your care.

INSURANCE

Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. As a courtesy, we may provide services such as pre-treatment estimates submitted to your insurance upon request. However, it is your responsibility to understand your specific benefits, limitations, deductibles, and coverage.

Some or all services provided may not be covered by your insurance plan. Any remaining balance is your responsibility regardless of insurance payment.

PAYMENT

Regardless of insurance status, you are responsible for all professional services rendered. This includes dental procedures, surgical services, diagnostic tests, medications, and any other related care.

Full payment is due at the time of service unless prior financial arrangements are made. Estimated patient co-payments and deductibles are due at the time of treatment. Any remaining balance after insurance processing may be charged to the authorized card on file in accordance with the Credit Card Authorization Form.

Unpaid balances exceeding ninety (90) days may be subject to interest, fees, and collection activity as permitted by law.

MISSED APPOINTMENTS & RESERVED CLINICAL TIME

Appointment times are reserved exclusively for each patient. When an appointment is missed or changed without adequate notice, another patient in need of care cannot be seen during that time.

Notice Requirements

* Hygiene appointments require at least 24 hours' notice.

* Doctor appointments require at least 48 hours' notice.

Courtesy Exception

Each patient is granted one courtesy late cancellation or missed appointment. After this courtesy has been used, additional late cancellations or missed visits may result in a cancellation fee or forfeiture of any reservation deposit.

Reservation Deposits for Doctor Time

Certain doctor appointments require a reservation deposit of $50 per scheduled clinical hour. This deposit is applied toward treatment on the day of service. If the appointment is missed or changed without the required notice after the courtesy exception has been used, the deposit may be forfeited.

Appointments requiring a deposit are not guaranteed until the deposit is received. Unsecured appointments may be released to other patients.

Emergency Consideration

We understand that true emergencies can occur. Fees or deposit forfeitures may be reviewed with appropriate documentation and adjusted at the discretion of the doctor or office management.

Courtesy Reset

A courtesy exception may be restored after twelve (12) consecutive months without a late cancellation or missed appointment, or after two (2) consecutive kept scheduled visits.

ACKNOWLEDGMENT

I have read, understand, and agree to the terms and conditions of this Financial Policy.

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. Bella Smile Dentistry 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. Bella Smile Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Bella Smile Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

We **recommend** enabling text and email so you receive automated reminders and updates. If you decline, we will not send **email** reminders. You may still ask us to remind you **by phone/voicemail**.

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

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. Bella Smile Dentistry, 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. Bella Smile Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Bella Smile Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

We **recommend** enabling text and email so you receive automated reminders and updates. If you decline, we will not send **text** reminders. You may still ask us to remind you **by phone/voicemail**.

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 Bella Smile Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bella Smile Dentistry.

Patient's signature: Date: