Kids Choice
PEDIATRIC DENTISTRY
INNOVATIVE DENTAL CARE FOR THE YOUNG ONES

Medical and Dental History Form

Patient's Name: _____ Date of birth: ___/___/_____ Gender: ___Female ___Male

Patient's Name: _____ Date of birth: ___/___/_____ Gender: ___Female ___Male

Patient's Name: _____ Date of birth: ___/___/_____ Gender: ___Female ___Male

Patient's Name: _____ Date of birth: ___/___/_____ Gender: ___Female ___Male

Patient's Name: _____ Date of birth: ___/___/_____ Gender: ___Female ___Male

Responsible Party Information

Legal Guardian/Parent of a minor child is responsible for account:

Parent's marital status: Single____ Married____ Widowed____ Separated____ Divorced____

Mother/Legal Guardian #1's Information

Name: _____ Home Phone:_____

Email Address: _____ Cell Phone:_____

Address: _____ Work Phone: _____

City: _____ State:_____ Zip code: _____

Employer: _____ Occupation:_____

Date of Birth: _____ Social Security #: _____

Father/Legal Guardian #2's Information

Name: _____ Home Phone:_____

Email Address: _____ Cell Phone:_____

Address: _____ Work Phone: _____

City: _____ State:_____ Zip code: _____

Employer: _____ Occupation:_____

Date of Birth: _____ Social Security #: _____

How did you hear about our office?_____

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Insurance Information

Patient Information

Patients Name: _____ Patient's DOB: _____

Patients Name: _____ Patient's DOB: _____

Patients Name: _____ Patient's DOB: _____

Are you or any other family member(s) covered under more than one insurance? [ ]Yes [ ]No

Primary Insurance Information

Insurance Primary Holder's Name: _____
Primary Holder's DOB: _____
Insurance Name: _____
Insurance Phone Number: _____
Member ID/SSN: _____
Group Number: _____
Employer: _____

Secondary Insurance Information

Insurance Secondary Holder's Name:

_____
Secondary Holder's DOB: _____
Insurance Name: _____
Insurance Phone Number: _____
Member ID/SSN: _____
Group Number: _____
Employer: _____

If divorced or legally separated, does the decree specify which parent is responsible for providing health and/or dental coverage for the children: Yes ____ No_____
If yes, who is responsible? _____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Bibiana Ezeanolue all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance's submissions.

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Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We are required that you give our office 24 hours' notice in the event that you need to reschedule appt. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $25.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $25.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

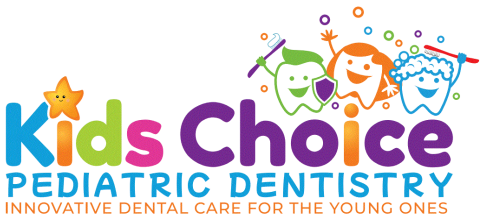
Patient Name(s):

_____ _____

_____ _____

_____ _____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature Date



Financial Policies

Our doctor and staff are pleased to welcome you as a new patient. To prevent any misunderstanding, regarding payment for treatment, carefully review and then sign the following financial policy.

Please be advised signing this form authorizes our office to use your personal identifiable such as your name, address, social security number, date of birth, spouse's information, you and/or your child's name and date of birth (but not limited to) the following purposes: daily sign in sheets, medical appointment cards, insurance claims or pre-treatment authorization, referrals, or for legal or collection procedures(HIPAA).

Patients with Dental Insurance: We will verify your insurance eligibility and coverage information so that claims may be submitted following treatment. Please remember to submit claims as a courtesy to our patients. Parents or legal guardians, are ultimately responsible for any balance on the account regardless of insurance involvement. The insurance contract is one between the subscriber(patient, parent/guardian) and the insurance company.

Insurance companies have a fee schedule of which they base benefit procedures. Your insurance may use an out-of-network fee schedule if we are not a contract provider. Benefit will be determined only when a claim is processed for payment. Benefits will also be based on your deductible, eligibility requirements at the time of treatments and any limitations, restrictions or exclusions specific to your policy. Policy information is available to you through the Human Resource Department at work or directly from your insurance company. It is the subscriber's responsibility to know their benefits, including frequency limits. You will be responsible for any and all payment for services denied by your insurance company for frequency limits regardless of what your explanation of benefits from your insurance company states is your responsibility. Co-Payment information is estimated only. For example treatment, a pre-treatment estimate may be submitted to your insurance. A pre-treatment estimate is not guarantee of benefits of payment. Actual benefit is not determined until your insurance receives an actual claim for processing.

While we do our best to provide accurate information and to collect the maximum benefit for treatment rendered, there are times when a balance will remain after you have made personal payment and insurance has made their payment. The person responsible is liable for any balance remaining on the account, regardless of insurance. There are no contract adjustments or write-off of any balance after an insurance company has made their payment. It is the subscriber's responsibility to respond to any and all insurance inquiries. Claims may be needed if additional information is needed regarding secondary insurance coverage, student status or paternal liability as result of divorce.

To all responsible parties: Regardless of insurance, any account over 45 days old will be due and payable. In the event that payment in full for changes incurred is not made, I agree to pay all costs of collection, including 40% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month(18% per year). It is understood that Kids Choice Pediatric Dentistry will submit delinquent account information to credit bureaus. All accounts sent to collection are subject to collection agency fee and possibly other legal costs in addition to balance owed.

I have read and understand the contents of this agreement and I agree to comply with the policies, payment from insurance or third party financing are payable directly to Kids Choice Pediatric Dentistry. Parent or Legal Guardian who signs this agreement is responsible for payment.

_____ _____

Print name of Parent/Legal Guardian **Signature of Parent/Legal Guardian**

_____

Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CANGET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect (03/01/2022),and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make the new notice upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Health Information

We used and disclosed health information about you for treatment, payment, and healthcare operations.

For example:

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your
- request, but we’ll tell you why in writing within 60 days.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- Get a list of those with whom we’ve shared information: You can ask for a list(accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as and you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and act for you before we take any action.
- File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S Department of Health and Human Services office for civil rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or
- visitingwww.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to bill and get payment from health plans or other entities.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To you family and Friends: We must disclose your health information to you, as described in the patient Rights section of this notice. We may disclose your health information to a family. member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that may do so.

Person involved in care: We may use or disclose health information to notify or assist in the notification of (Including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make.

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Patient Acknowledgment of Receipt of Notice of Privacy Practice and Financial Responsibility

This Health Insurance Portability and Accountability Act, HIPAA, requires that effective March 1,2022, patients be given a copy of Notice of PrivacyPractices.

"I acknowledge, I have received from this office, a copy of the Notice of Privacy Practices" andAppointment Cancellation Policy.

"I further acknowledge and agree that all accounts past 30 days shall bear a compoundinginterest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay forservices rendered, Kids Choice Pediatric Dentistry may place my account with a collectionagency. I agree to pay reasonable collection fees, attorney fees and court costs incurred inthecollection of my overdue account."

I understand, there will be a $25.00 no show, broken appointment and cancellation fee without24 hours notice.

_____
Print Parent/Legal Guardian's Name

_____
Signature of Parent/Legal Guardian

_____
Date