MOSAIC PERIODONTICS

Mosaic Periodontics
6045 S. Fashion Blvd #203, Murray Utah 84107
(801) 207-7070
www.mosaicperio.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
		Marital status:	
		Employer:	
		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:	

Emergency Contact

Emergency Contact	
Emergency Contact Phone Number	
Relationship to Patient	

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: 166 E 5900 S Suite B101 Murray, UT 84107

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 clients 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 individuals 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 individuals 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.

By signing below, I confirm and agree to the above information:

X _____

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FINANCIAL AND INSURANCE ACKNOWLEDGEMENT

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

Please be prepared to pay your estimated portion at the time of service regardless of insurance coverage. Please be prepared to show evidence of insurance (if applicable) and photo ID at all appointments.

1. Professional services are rendered to the patient and not the insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by the insurance company.

2. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond which this agreement allows.

3. As a courtesy, our office will verify your plan with your insurance carrier. In addition, we will file your dental claim with your insurance carrier and ESTIMATE your portion due at the time of treatment. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment. If your dental claim is denied it is your responsibility to follow up with the insurance company. We are happy to work with you and the insurance for up to 60 days after the date of service. All denied or unpaid/processed claims after 60 days will become due if a balance is carried by the office during this time. Please be aware that your dental insurance plan is a contract between you, your employer, and the insurance company. It is your responsibility to know the benefits, limitations, and exclusions of your dental plan. We are not responsible, nor can we guarantee, how your insurance carrier will pay on a claim. Please note that treatment plans change on occasion during treatment because conditions can worsen or improve and can therefore change your financial responsibility in either direction. Your deductible and/or copay is due at the time services are rendered. Because your insurance company makes no guarantee of payment, we cannot always guarantee your exact insurance coverage. Therefore, you may receive a statement with an additional balance after your insurance has met their obligation. We ask that your account balance be paid at the time of service or within 15 days of receiving such statement. We are always available to answer your questions and/or assist you in any way we can. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed and that it is my responsibility to notify the office of any changes in my insurance.

AGREEMENT TO PAY

1. For your convenience we will ESTIMATE the portion of your total fee your insurance company will cover. This is JUST AN ESTIMATE. You are responsible for ANY UNPAID BALANCE. We will ask you to bring at the time of surgery the ESTIMATED uncovered portion of the total fee.

2. I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys fees, with or without suit, incurred in collecting any past due balance, and a collection fee of up to 40% of the remaining unpaid balance if my account is assigned to a collection agency.

3. I agree that if there is a dispute as to the care or treatment for the services provided, that either party may elect to have the claim resolved in arbitration, and that I will pay all costs of arbitration. This agreement to arbitrate revokes any previous arbitration and/or mediation agreement previously signed by myself or my agent. The forgoing arbitration agreement specifically excludes actions taken for the collection of debts owed as result of services provided.

4. You agree, in order for us to service your account or collect any amount you may owe, we may contact you by telephone at any telephone number, including wireless telephone numbers that you have or may attain which could result in charges to you. We may also contact you by sending text messages to any telephone numbers that you have or may attain, or email using any email address owned by you. Methods of contact may include pre-recorded or artificial voice messages.

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

By signing below, I confirm and agree to the above information:

X _____

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COMMUNICATION CONSENTS

CANCELLATION POLICY

In consideration for our patients, the cancellation/missed appointment policy is as follows: Please note that any appointment cancelled or missed without a 24 BUSINESS HOUR NOTICE by phone call may be assessed a minimum of a $50.00 fee per hour that the appointment was scheduled. Cancellation by email or text does NOT qualify as an acceptable form of notification. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read and agree to Mosaic Periodontic's Cancellation Policy.	Initals:

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Mosaic Periodontics 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. Mosaic Periodontics will use reasonable means to protect the security and confidentiality of email information sent and received. However, Mosaic Periodontics 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 Mosaic Periodontics and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Mosaic Periodontics.

- ☐ I consent to receiving information by email
- ☐ I do not want to receive information by email

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

☐ I consent to receiving information via text message

☐ I do not want to receive information via text message