Lake Bowen Dental Studio
1242 Parkside Acorn Dr, Inman, SC 29349
(864) 578-9366
www.lakebowendentalstudio.com

NEW PATIENT FORM

Basic Information

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

Contact Information

Address Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

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: 1242 Parkside Acorn Dr, Inman, SC 29349: 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

We strive to provide you with the highest quality care at a reasonable price. Timely payment on your account helps us to keep our costs down; in order to facilitate this, we offer the following payment options.

1. 50% down/ 50% at time of delivery

This applies to procedures that require 2 or more office visits, such as crowns, bridges, implants, dentures & partials, night guards, etc.

2. INSURANCE (office-filed)

We will file your claim with your insurance company. Payment of your estimated portion not covered by insurance is expected at the time of the treatment/visit.

3. CARE CREDIT

This is a third-party credit-based payment plan that allows for payments to be made for a period of six months interest-free. Longer financing is also available with interest. The application process is very simple, speak with the front office personnel if you have any questions or visit www.carecredit.com.

4. LAKE BOWEN DENTAL STUDIO MEMBERSHIP CLUB

This membership club is offered to all patients without dental insurance and is based on a monthly subscription. The process to sign-up is very simple, speak with the front office personnel if you have any questions.

Balances not paid after 30 days are subject to a monthly administration fee. Balances not paid after 90 days will be turned over to a collection agency for payment if prior arrangements have not been made.

OFFICE POLICY

Your dental health is very important to us, and in order to facilitate high-quality dental care for you in a timely manner, it is important that you keep your appointment with us.

When we schedule your appointment, we are reserving time exclusively for you. If for some reason you cannot keep your scheduled appointment, kindly give us 24 hours notice.

Appointments broken without 24 hours notice will be subject to a $25 fee.

We appreciate your confidence in us as your dental provider and look forward to seeing you!

By signing below, I understand and agree to the Financial and Office Policies as 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. Lake Bowen Dental Studio 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. Lake Bowen Dental Studio will use reasonable means to protect the security and confidentiality of email information sent and received. However, Lake Bowen Dental Studio 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 Lake Bowen Dental Studio and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Lake Bowen Dental Studio.

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

Patient's signature: Date: