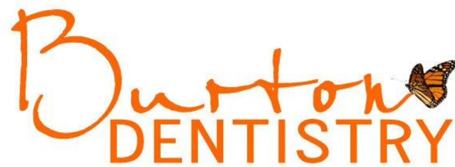

Burton Dentistry No Show/Cancellation Policy

EFFECTIVE 05/01/2014

Dear Patient,

Thank you for entrusting your dental care to Burton Dentistry! We are dedicated to providing you with the best possible care in a friendly and efficient environment. To achieve these objectives, we must develop a cooperative and symbiotic relationship with our patients. In fostering this relationship, we have streamlined the appointment process to provide greater coordination of patient flow within our office. One of the foundations of the policy is an appointment reminder system. This system sends reminders at strategic time intervals before each appointment; therefore, we require patients to provide us with an E-mail address and a cell phone number to facilitate the reminders. Patients are also required to respond to the reminders, either by confirming or canceling their appointments as instructed, as we will no longer place courtesy reminder calls.

If you do not respond to the reminders, your appointment may be assigned to a patient on our waiting list. If you need to cancel your appointment, please provide a minimum of 48 hours. Our no show/cancellation fee is $50.00.

PATIENT PRIVACY & PRACTICE POLICIES (PLEASE INITIAL ALL ITEMS BELOW)

DENTAL RECORDS RELEASE: The practice requires a $10.00 fee for researching, copying and mailing (if applicable), each dental record. The fee is due in full prior to their release. _______Initials

FINANCIAL: Your understanding of our financial policies is an essential element of your care and treatment. For your convenience we accept cash, checks (minimum $20.00), Visa and MasterCard. Full payment is due at time of service. There is a $50.00 returned check fee.

_________Initials

INSURANCE: We have made prior arrangements with many insurance plans. We will bill those plans with which we have an arrangement and will collect co-pays and/or deductibles at the time of service when you arrive for your appointment. In the event your dental plan determines a service to be non-covered, you will be responsible for the complete charge. Subsequently, we will bill you directly and payment is due upon receipt of the statement. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. ______Initials

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay for the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. ________Initials

CANCELLATION: To avoid a fee of $50.00, please do the following:

*Allow 48 hours advance notice when cancelling your appointment. _______Initials

I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.

____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN)

________________________________ ___________________________

PRINT NAME OF PATIENT (MINOR) DATE

Dr. Fr[illegible]esca M. Burton, D.D.S., P.C.

ADA
American Dental Association
www.ada.org

Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY)		(STATE / ZIP CODE)
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bladder
❑ Bleeding disorders
❑ Bones/Joints
❑ Cancer
❑ Cerebral Palsy
❑ Chicken Pox
❑ Chronic Sinusitis
❑ Diabetes
❑ Ear Aches
❑ Epilepsy
❑ Fainting
❑ Growth Problems
❑ Hearing
❑ Heart
❑ Hepatitis
❑ HIV +/AIDS
❑ Immunizations
❑ Kidney
❑ Latex allergy
❑ Liver
❑ Measles
❑ Mononucleosis
❑ Mumps
❑ Pregnancy (teens)
❑ Rheumatic fever
❑ Seizures
❑ Sickle cell
❑ Thyroid
❑ Tobacco/Drug Use
❑ Tuberculosis
❑ Venereal Disease
❑ Other ____________

Please list the name and phone number of the child's physician:

Name of Physician ______________________________ Phone ______________

Child's History

	Question		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: ____________	1.	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ____________	2.	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: ____________	3.	❑	❑
4.	How would you describe the child's eating habits? ____________			
5.	Has the child ever had a serious illness? If yes, when: ________ Please describe: ____________	5.	❑	❑
6.	Has the child ever been hospitalized?	6.	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: ____________	7.	❑	❑
8.	Has the child ever received a general anesthetic?	8.	❑	❑
9.	Does the child have any inherited problems?	9.	❑	❑
10.	Does the child have any speech difficulties?	10.	❑	❑
11.	Has the child ever had a blood transfusion?	11.	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	12.	❑	❑
13.	Does the child experience excessive bleeding when cut?	13.	❑	❑
14.	Is the child currently being treated for any illnesses?	14.	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ________	15.	❑	❑
16.	Has the child had any problem with dental treatment in the past?	16.	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	17.	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	18.	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	19.	❑	❑
20.	Has the child had any orthodontic treatment?	20.	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water			
22.	**Does the child take fluoride supplements?**	22.	❑	❑
23.	**Is fluoride toothpaste used?**	23.	❑	❑
24.	How many times are the child's teeth brushed per day? ________ When are the teeth brushed? ________	24.	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	25.	❑	❑
26.	At what age did the child stop bottle feeding? Age ________ Breast feeding? Age ________			
27.	Does child participate in active recreational activities?	27.	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ______________________________ Date ______________

For completion by dentist

Comments ______________________________

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by ______________

Date ______________

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Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Insurance Verification Form

Dear New Patient,

The Information you will provide will be kept confidential as per HIPPA regulations. As a service to our patients, we accept and file dental insurance. However, **YOU** are responsible for **ALL** communication with your insurance company except for additional information required of this office pertaining to specific procedures. Please understand that dent insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible which must be paid by the patient at the time of service. **We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.**
Thank you for your cooperation!

Please provide the following information from your dental insurance card:

Patient's Name: ______________________________ D.O.B:_____/______/__________

Name of Policy Holder: ______________________________

Relationship to Policy Holder: ______________________________

Policy Holder's Social Security Number: ________-_________-_________ Policy's Holder D.O.B:____/____/____

Policy's Holder Employer Name: ______________________________

Dental Insurance Company Name: ______________________________

Group Number: ______________________

Insurance Company Phone Number: ______________________________

Insurance Company Claims Address: ____

Authorization

I certify that I am covered by__________________ insurance company and I assign directly to Dr.__________ all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________ Signature

_____/_____/________ Date

Burton Dentistry, P.C.
1900 Elkin Street, Suite 290 Alexandria, VA 22308 (703) 799-4300 visit us at www.burtondentistry.com

Financial Policy

Thank you for choosing our practice to provide for your dental health care needs. We are committed to delivering excellent service to our patients, and a part of that includes thoroughly explaining the office financial and insurance policies, as well as the cancellation policy, so that our responsibilities to one another are clearly defined.

Payment in full, and/or any insurance co-payments, are due at the time of service unless other financial arrangements have been made.

A $25 billing fee will be applied to accounts unpaid for 60 days or more and the account may be reported to a collection agency for settlement.

In the effort to hold costs down, payment is due when services are rendered. We accept cash, check, VISA, and MasterCard. A 5% courtesy will be extended to patients who pay for treatment over $500 in full when scheduling their appointments, or who pay in full at the first of multiple appointments.

Lab related services such as crown, implant crown and bridge, partial and full dentures require 50% at the preparation date and 50% at the completion date. If you have insurance benefits on these services, you must pay half of your portion at the start date and the remaining half when the service is completed.

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless scheduled procedures and charges have been pre-authorized in writing by the parent or legal guardian.

In the event that you need to request a duplication of your dental records or x-rays, you are required to fill out a release form. There will be a fee of $10 for each record you request. Payment is due upon request of duplicating services.

Insurance Policy

Please understand that dental insurance is meant to assist you with paying for dental treatment, and is not meant to cover all services in full. To assist you in the insurance process, our office team has undergone extensive training to maximize your insurance benefits, while reducing the time it takes the insurance companies to pay. Our office will submit all claims electronically, when possible.

As a courtesy, we will submit your insurance to your primary insurance company for dental treatment provided in our office. You are responsible for providing us with current and accurate insurance information at all times. Any changes in insurance coverage should be given to us at the beginning of your appointment.

If your insurance company has not provided payment to our office within 45 days, any balance on your account will become your responsibility.

Cancellation Policy

In fairness to other patients and the doctor, we request that you kindly give 48 hours notice if you must cancel an appointment. We reserve the right to charge up to 50% of the scheduled appointment's fee if 48 hours notice is not given.

An appointment will be considered cancelled if the patient fails to give 48 hours notice (by 11 a.m. Thursday for a Monday appointment), does not arrive for an appointment, or if the patient arrives more than 15 minutes late to an appointment. Patients who are late may be rescheduled so that those who are on time are not inconvenienced.

Patients with a history of more than 3 last minute cancellations may be asked to pre-pay for their appointments prior to being scheduled.

As a courtesy to our patients, we will attempt to remind you of all appointments via telephone at least 48 hours prior to the appointment. However, you are responsible for keeping all scheduled appointments, even if no confirmation call is received.

I have read the above policies in their entirety. I understand and agree to abide by all aspects of the above policies. Any questions I may have had regarding these policies have been answered to my satisfaction.

X________________________________
Patient Signature

Date ______/______/______

Burton Dentistry, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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