AUGUSTA REGIONAL DENTAL CLINIC

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ /_____ /_____ Gender / Ethnicity: _____Social Security #: _____ - _____ - _____

Primary Phone #:_____ Secondary Phone #:_____

Mailing Address: _____

(P.O. Box or Street Address) (City) (State) (Zip Code)

County or City of Residence: _____

Emergency Contact Name: _____ Phone Number: _____

Do you have any dental insurance (including Medicaid): [ ] Yes [ ] No If yes, what type? _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with the above listed Insurance Company and assign directly to the Augusta Regional Dental Clinic 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 submissions. The Augusta Regional Dental Clinic may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

_____ **1. Patient Appointment Policies**

Confirmation: We will attempt to confirm your appointment 2 business days prior. However, you must contact the clinic by 2pm the day prior to your appointment to confirm. Failure to do so will result in the appointment being cancelled. It is your responsibility to keep your contact information updated with the clinic. If your phone is disconnected, unable to receive messages, or if we are unable to leave a message, the appointment will be cancelled. Please arrive for your scheduled appointments on time. If you arrive more than 5 minutes late, we may reschedule your appointment and you will lose your pre-paid deposit. You must give at least 24 hours' notice if an appointment is being cancelled or rescheduled.

Cancellations/No Shows: If you do not provide 24 hour notice to cancel or reschedule an appointment, we will be unable to reschedule you for six months or longer due to the volume of future patient appointments and you will lose your pre-paid deposit. Two No-Shows or Short Cancellations within a 12 month period means your clinic privileges are suspended indefinitely and you will lose your pre-paid deposit.

_____ **2. Treatment Plan Policy**

If patient does not agree with the treatment plan, and their non-compliance jeopardizes the ARDC's ability to deliver an acceptable standard of care, or the patient insists upon a treatment that is not feasible at the clinic, patient will be required to seek care in private practice, or be dismissed from the clinic based on the individual situation.

_____ **3. Conduct Policy**

The Dental Clinic is here to provide you and your children with the best care possible. Be respectful and cooperative to ARDC staff members as well as other ARDC patients; rude behavior or profane language will not be tolerated. Any patient thought to be intoxicated or chemically impaired at any time, will be denied services or treatment and faces possible dismissal from the clinic. The ARDC reserves the right to determine whether a patient shall or shall not receive services at our Clinic. If you have a complaint or concern about the service you have received from the staff, please let us know. Our complaints system adheres to state criteria.

*When adults are being treated, their children may not accompany them into the dental operatory. The dental department cannot provide child care while a parent is being treated.

_____ **4. Payment Policy**

Advance payment is required before each dental visit and must be cash, money order or Visa/MasterCard/Discover/American Express. NO CHECKS ACCEPTED. This policy does not apply to children with Medicaid coverage.

_____ **5. Narcotic Prescription Monitoring System Policy**

Augusta Regional Dental Clinic participates in the Virginia Prescription Monitoring System.

_____ **6. Medicaid Patients: Non-Covered Services**

We will submit dental insurance claims to Medicaid on the patient's behalf. Every attempt will be made to collect payment from your insurance. In the event that the patient needs a service that is considered a "non-covered benefit" the patient will then be responsible for payment of these services. Our fees are based upon your income and Medicaid eligibility status. Our front office coordinators will assist you in understanding your bill should you receive one.

_____ **7. HIPAA Privacy Practices, Consent for Treatment, Deemed Consent**

I agree to the ARDC Notice of HIPAA Privacy Practices, Consent for Treatment and Deemed Consent and understand that a printed form is available should I choose to receive a copy. These consents are also posted in the lobby. By requesting care in the Dental Clinic, I am giving the dental provider permission to examine, diagnose and treat me (or my child). In the event of a blood borne pathogen exposure, I am deemed to have consented to testing and release of results to those exposed. I acknowledge that I will be thoroughly counseled before any testing as a result of exposure.

Patient or Parent/Guardian Signature

Date