Purcellville Pediatric Dentistry

novatoothfairy.com
smiles@novatoothfairy.com
17333 Pickwick Dr., Suites A&B • Purcellville, VA 20132
(540)441-7627

Welcome to The Tooth Fairy Dentist!

Please complete this form with parent and guardian information. Only one Parent/Guardian Registration Form is needed per family. After you've completed this form, please complete a Patient Registration Form for each of your children. Thank you.

Person Responsible for Payment: Mother, Father or Guardian Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______ Last ______ First ___ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ **SS#:** ___-__-____ **DL#:** ______

Email Address: ______ **Best time to call:** ______

Phone: ______ Home ______ Mobile ______ Work ______ Ext ______ Fax ______ Other

Address: ______ Address 1 ______ Address 2

______ City ______ State _____-____ Zip Code

Second Parent or Guardian Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______ Last ______ First ___ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ **Email Address:** ______

Phone: ______ Home ______ Mobile ______ Work ______ Ext **Best time to call:** ______

Address: ______ Address 1 ______ Address 2

______ City ______ State _____-____ Zip Code

Who is the primary custodian?

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

How did you hear about Purcellville Pediatric Dentistry?

______

Dental Benefits Plan

Primary

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Secondary Dental Benefits Plan - If Applicable

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

☐ ***By checking this box I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Financial Agreement And Consent for Services

Thank you for choosing Purcellville Pediatric Dentistry for your dental treatment. Purcellville Pediatric Dentistry believes that everyone benefits from a clear financial agreement before treatment. This Payment Agreement is between Purcellville Pediatric Dentistry, a Virginia Professional Corporation, and you, the patient (or, if the patient is a minor, the patient's parent(s) or legal guardian). The terms of this Payment Agreement cover this visit and all future visits. This Payment Agreement amends the terms of any prior payment agreements you have had with Purcellville Pediatric Dentistry.

Payments for today's visit and your future visits are due at the time of treatment. If you have dental insurance coverage, payment of the estimated patient co-payment is due at the time of service. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PART OF THAT CONTRACT. IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS. We file insurance claims on your behalf in order to help you get the coverage to which you are entitled. If your insurance company does not remit payment within 30 days after claims have been submitted, the balance will be required from you. The balances (including amounts due after insurance is partially paid or denied) must be paid within 30 days of receipt of our invoice.

While we are sensitive to divorce situations, our policy is to hold the parent seeking treatment for their child responsible for any charges not covered by insurance.

We Do NOT Participate with any HMO OR DMO Insurances

If you have an insurance plan that we do not participate with, you will be responsible at the time of service for any copay or percent of charges that your insurance plan does not cover. We will submit the claim on your behalf. All balances (including amounts due after insurance is partially paid or denied) must be paid within30 days of receipt of our invoice.

Payment Options and Customary Rates

We accept cash, checks, and Visa, Mastercard, and Discover credit or debit cards. For payment plan options ask us about Care Credit. We are pleased to offer 6 month or 12 month interest free financing for balances over $200.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Interest

All balances (including amounts due after insurance is partially paid or denied) must be paid within 30 days of receipt or your invoice. Balances remaining after this time will be subject to interest at a rate of 10% per year.

Broken Appointments

We understand that occasionally circumstances arise that prevent you from keeping your appointment. However, because time is reserved exclusively for you with the dentist, if you break an appointment with less than 48-hours notice there will be a charge to your account for $50 for each appointment that is broken. Your insurance company does not cover this charge. (If you provide us with a doctor's note, or if there is a family emergency, we will credit the broken appointment fee.)

Practice Dismissal

Occasionally, we may find it necessary to dismiss a family from the practice. Reasons for this include, but are not limited to, the following: recurrent late or missed appointments; noncompliance with recommended dental care; nonpayment of bills; threatening, abusive, or rude behavior toward office staff, doctors, or other patients and families.

Collection Costs, Attorney's Fees, and Returned Checks

You also agree to pay all costs of collections and attorney fees in an amount equal to 35% of the balance due on your account. There will be a $25 fee assessed on all returned checks.

Law of the Commonwealth of Virginia

This Agreement shall be construed in accordance with and governed by the laws of the Commonwealth of Virginia.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment of my insurance carrier to submit payment directly to the dentist or dental practice to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

☐ * **By checking this box I acknowledge that I have read the above Financial Agreement and Consent for Services. This will serve as my electronic signature.**

Privacy Practices and HIPAA Authorization

I understand that I may inspect or copy the protected health information described by this authorization. A digital copy of Purcellville Pediatric Dentistry's Privacy Practices can be found on our website at www.novatoothfairy.com/patient-forms.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ ***By checking this box I give permission to Purcellville Pediatric Dentistry to use or disclose relevant health information. I understand the above information and agree with its contents, and this will serve as my electronic signature for the Privacy Practices and HIPAA Authorization.**

Consent for Internet Communications

I grant my permission to Purcellville Pediatric Dentistry to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand that Purcellville Pediatric Dentistry and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand that Purcellville Pediatric Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify Purcellville Pediatric Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand that Purcellville Pediatric Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Purcellville Pediatric Dentistry has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand that Purcellville Pediatric Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand that Purcellville Pediatric Dentistry CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***By checking this box I confirm that I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

☐ ***By checking this box I give Purcellville Pediatric Dentistry permission to transfer images/x-rays by email to other offices if requested.**

Permission to Use Photographs and/or Images

I give Purcellville Pediatric Dentistry permission to use my child's photograph or photographic image in official Purcellville Pediatric Dentistry business, including; newsletters, advertising, social media and website, etc. *

◯ Yes ◯ No

COVID-19 Consent

Our office complies with the State Health Department and the Center for Disease Control and Prevention infection control guidelines to prevent the spread of COVID-19. Our goal is to provide a safe environment for our patients and staff. Our staff are symptom-free and, to the best of our knowledge, do not present a risk of having COVID-19. However, since we are a public space, other persons (including other patients) could be infected, with or without their knowledge. Due to the nature of dental procedures, there may be an increased risk of contracting COVID-19 in a dental office or with dental treatment.

☐ ***By checking this box I understand and accept the risk of contracting COVID-19 from contact with this office. I also acknowledge that my child(ren) and I you could contract the COVID-19 virus from outside this office and unrelated to your visit here.**

Name of the person completing this form and your relationship to the patient: *

____

____

Response Date: __________