Practice Questions, Consents, and Policies

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mint. *
dental studio

Tell Us About You!

* What qualities do you look for in a dentist and dental team?

* What was the reason you left your last dentist?

Help Us Make You Smile:

* Are you happy with the color of your teeth? yes ☐ no ☐
* Do you wish your teeth were straighter? yes ☐ no ☐
* Is there anything you would like to change about your smile?

Consent for Exam:

Consent for exam, any appropriate hygiene services and life saving procedures

I, the undersigned patient, hereby authorize the Mint Dental, LLC to perform the procedure(s) or course(s) of treatment listed below including but not limited to comprehensive evaluation of my oral condition, diagnostic tests, radiographs, diagnostic casts, cleaning of my gums and teeth and fluoride application if needed. I understand that the risks associated with cleaning of my gums and teeth include: tenderness of gums lasting several days after the cleaning, transient sensitivity of my teeth to temperature and soreness of my jaw from holding my mouth open. I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment. I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure. I understand I may be offered to have my jewelry (rings, etc.) cleaned with an ultrasonic jewelry cleaning device during my appointment. I understand Mint Dental, LLC is not responsible for any damage to my jewelry, including loose or lost stones.

Financial Policy:

I understand that payment for care is due the day it is received. I am aware that MINT* Dental Studio is out of network for all insurance companies, but will submit if appropriate dental benefit paperwork on my behalf. Unless prearranged with MINT* Dental Studio, unpaid balances will be assessed a 10% monthly fee.

HIPAA Policy:

This contains information concerning HIPAA (Health Insurance Portability and Accountability Act) which are written to protect the confidentiality of your health information. This information was updated on September 23, 2013.

The federal government legally enforces the privacy of health information. The government has sought to standardize and protect the privacy of electronic exchange of your health information. We want you to know about these policies which we have put into place to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws we want you to understand our procedures and your rights as our valuable patient. We will use and communicate your health information only for purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission. It is our obligation to notify you in the event of a breach of unsecured personal health information.

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment. We may also share your health information with anyone providing at home care, payment or in case of an emergency and we need to contact someone for medical assistance. Your protected health information will not be used for fundraising, marketing or be sold.

We may use your health information with an invoice to obtain payment for treatment received in our office. We may also do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information. Your health information may also be reviewed during the routine processes of certification, licensing or credentialing activities of our dental staff.

We believe that regular care is very important to your oral and general health. We will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on the care you received in our office. Our office currently uses texts, emails and postcards to remind you of future appointments that you have or need. Please let us know if you would not like to receive these reminders. You have a right to an electronic copy of your health records.

We will notify government authoriti es if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement. We may also be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. As permitted or required by State or Federal law, we may disclose your health information for law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Other than what is stated above, or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

This new law is careful to describe that you have the following rights related to your health information:

- You have the right to request restrictions on certain disclosures of your health information.
- You have the right to request that we communicate with you in a certain way.
- You have the right to read, review and copy your health information, including your complete chart, radiographs and billing records.
- You have the right to ask us to update or modify records if you believe your health information records are incomplete or incorrect. You must provide your request in writing with the reason for the change. Your request may be denied if the health records in question were not created by our office.
- You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from May 19, 2003 and forward. Please let us know in writing the time period for which you are interested. We may need to charge a reasonable fee for your request.
- You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised notice.
- If you pay for your services in- full, out of pocket, you have the right to request that we do not disclose treatment information for these services to a health plan.
- You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please let us know any concerns or complaints in writing.

Cancellation Policy:

Please help us deliver outstanding and timely dental care to you and busy patients like you! We know and appreciate that you want to achieve and maintain health, but sometimes lead a hectic life. We are happy to seek to find a convenient appointment time for you or to reschedule any appointment if needed. If you find that you need to change an appointment time, please provide us with TWO BUSINESS DAYS NOTICE. This ensures that other busy patients like you can be seen in a timely manner and helps keep costs down so that we may offer you affordable dental care. Please know we may elect to charge a $100.00 cancellation fee for cancellations made with less than two business days notice.

Minor/Child Consent:

I, being the parent or guardian of said child do hereby agree to the above consents and policies on behalf of my child whether or not I am present at the actual appointment when the treatment is rendered.

Acknowledgment:

* Relationship of person completing this form to patient _____

* Name of person signing this form (If not the patient) _____

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Signature

Date