Kim Le D.D.S.,M.S.
Cosmetic, Restorative & Implant Dentistry
990 Highway 287 North, Suite 112
Mansfield, Texas 76063
Telephone: 817-473-6677

Patient Information

Patient Name: _____
First MI Last (Preferred Name)

Gender: Male or Female Family Status: Single Married Child Other

Social Security #: _____ Date of Birth: _____

Email: _____

Responsible Party: _____
First Last Address (if different from below)

Home Phone: _____ Mobile: _____ Work: _____

Address: _____
Street Apartment #

City: _____ State: _____ Zip Code: _____

How did you hear about our office? _____

Insurance Information

Primary Insurance
Name of Policyholder: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer: _____

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

If you have a Secondary Insurance: Our office will be happy to help you file your insurance; however, the insurance payment from the insurance will be paid directly to you.

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions Undersigned hereby authorizes Dr. Kim Le to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Kim Le to make a thorough diagnosis of patient's dental needs. I also authorize Dr. Kim Le to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that doctor Dr. Kim Le choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Patient, Parent or Guardian Signature Date

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Health Information

Patient's Name: _____ DOB: _____ Phone #:_____

Address: _____ Email: _____

Preferred Pharmacy Address: _____ **RX Phone #:**_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies: _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bruises easily
- ☐ Cancer
- ☐ Chemo
- ☐ Cholesterol
- ☐ Codeine Allergy
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Iodine Allergy
- ☐ Jaundice
- Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Currently Pregnant
- ☐ PRE- MED- Reason _____
- ☐ OTHER: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have a cardiac pacemaker? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had Heart Surgery? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list any medications you are currently taking, including over the counter

_____

_____

_____ _____ _____

Patient, Parent or Guardian Signature Date Doctor's Signature

Kim Le
D.D.S., M.S.

We accept Cash, Check, All Major Credit Cards, and Care Credit.

Financial Agreement

1. I, _____, understand that my insurance coverage is an agreement between myself or the primary policy holder and the insurance company.
2. Kim Le D.D.S., M.S., Dr. Kim Le, are third parties to this agreement. Kim Le D.D.S., may accept co-assignment of my benefits where applicable.
3. The amount of insurance coverage **estimated** for treatment at Kim Le D.D.S., is based on information I have provided and other information obtained directly from the insurance company, which may result to be inaccurate in part or entirely.
4. By signing this agreement, I represent that I will be financially responsible for any and all portions of my balance not received from my insurance company.
5. I agree to **pay my portion of today's treatment fees in full.**
6. I agree that if I become **delinquent in a payment plan** established with Kim Le D.D.S., that I will be billed for the entire remaining balance and will be expected to pay in full immediately. **I am also aware that I will have a non-refundable delinquent fee of $35.00.**
7. I agree to pay a finance charge of 1.5% per month for any balance not received in full within 60 days of this signed agreement. The full APR is 18%. This became effective as of February 1,2010.
8. I agree to pay **a $40 charge** for any checks returned from my bank for any reason.
9. No-shows are not acceptable. I understand that if I do not contact the office ahead of missing an appointment (i.e., 24 hours advance notice unless it's an emergency), I will be responsible for a **$75 non-refundable missed appointment charge**.
10. I understand that if my account remains unresolved after 60 days with Kim Le D.D.S., Kim Le, I will be responsible for all charges our practice incurs; including collection fees, court cost and reasonable attorney's fees.
11. I understand that a **collections agency** may also be used. This is dependent on the amount due to Kim Le D.D.S., M.S.
12. Kim Le D.D.S., M.S., files and processes insurance claims for our patients as a courtesy and is a third party in the contractual agreement between the patient and their insurance company. After 60 days post-treatment all unpaid balances including pending insurance claims and potential payments will become due immediately and the patient will be responsible for paying the unpaid balance in full.
13. I understand that Kim Le D.D.S., M.S., runs **a Zero Balance Office;** I understand that I am to pay in full prior to or at the time treatment is provided. I understand that in order to schedule an appointment for treatment with Dr. Le, she requires a 50% of the total patient out-of-pocket expense is due to reserve the time of that appointment.

Any bank charges associated with stop payments, insufficient funds, etc., will be added to your account.

_____ _____

Signature of Patient or Responsible Party Date

Kim Le
D.D.S., M.S.

Text Message/E-mail Consent Form

(Mark all that Applies)

I Authorize contact from Dr. Kim Le's dental practice to confirm my dental appointments via:

_____ Phone Call (Cell, Home, Work/Other)

_____ Text Message to Cell Number

_____ E-Mail

I Authorize Information about my dental Health to be conveyed via:

_____ Phone Call (Cell, Home, Work/Other)

_____ Text Message to Cell Number

_____ E-Mail

_____ In-Person Only

(Initial One)

_____ I **agree** that the dental practice may communicate with me electronically at the email address I provide, and I am responsible for providing the dental practice ay updates to my email address. **(* I am aware that there is some level of risk that third parties might be able to read unencrypted emails)**

_____ I **DO NOT** give consent for the dental practice to communicate with me electronically.

(Initial Here)

_____ To respect the privacy of our patients it is Dr. Kim Le's Dental Practice policy that there is no photography or recording permitted in the practice. Thank You for your cooperation and understanding.

_____ _____

Patient or Guardian Signature Date

Kim Le
DDS., M.S.

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

_____ _____

Patient or Guardian Signature Date

COVID-19
WAIVER OF LIABILITY AND RELEASE AGREEMENT
(Patient)

THIS IS AN IMPORTANT DOCUMENT. YOU MUST READ IT BEFORE SIGNING. IN SIGNING THIS DOCUMENT, YOU ARE WAIVING IMPORTANT LEGAL RIGHTS.

In consideration for the opportunity to receive dental treatment from Dr. Kim Le (the "Practice") and the professionals retained thereby, at the Practice's office located at 990 HWY 287 N. Suite 112 Mansfield, TX 76063 (the "Practice's Office"), and for other good and valuable consideration, I, _____ (the "Patient"), hereby state and agree as follows:

1. I recognize that my obtaining dental treatment at the Practice's Office presents risks to me, including the risk of coming in contact with the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or my contracting coronavirus disease (COVID-19), including my risk of severe illness and/or death.

2. I hereby release, acquit, waive all claims against, and forever discharge the Practice and its owners, successors, assigns, affiliates, officers, directors, administrators, representatives, principals, agents, servants, employees, independent contractors, insurers, and attorneys (collectively with the Practice, the "Indemnified Persons"), of and from any and all claims, charges, demands, promises, acts, agreements, costs, damages, debts, obligations, actions, causes of action (including but not limited to all avoidance actions of any type), suits in equity, expenses, executions, judgments, levies, liabilities, losses, and attorneys' fees, of whatever kind or nature, whether legal or equitable, liquidated or unliquidated, fixed or contingent, direct or indirect, suspected or unsuspected, accrued or unaccrued, known or unknown, present or future, asserted or unasserted, based upon, arising out of, appertaining to, or in connection with my exposure to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or my contracting coronavirus disease (COVID-19) as a result of or in connection with my entry into the Practice's Office, receiving dental treatment at the Practice's Office, or coming in contact with any Indemnified Person at or near the Practice's Office, and all related costs, expenses, illness, or death I may suffer as a result.

3. The releases set forth and otherwise referenced herein shall be interpreted as broadly as possible and shall be completely binding and enforceable at law. I acknowledge that the releases and waivers provided for herein include all claims and/or costs, including but not limited to those they do not know or suspect to exist, and hereby waive all rights which may exist with regard to such claims and/or costs. I expressly waive the provisions of any federal, state, and local statute or regulation limiting release of unknown claims, including any statutory language stating as following: "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY, AND ANY SIMILAR LAW."

4. For Parents/Guardians: In addition to the foregoing, we/I further waive all claims against (to the same extent described in Paragraph 2), and agree to hold harmless and indemnify, the Indemnified Persons and each of them, for any illness, death, costs, expenses, or other loss sustained by the Patient which results in any way from the Patient's entry into the Practice's Office, receiving dental treatment at the Practice's Office, or coming in contact with any Indemnified Person at or near the Practice's Office.

5. I agree that I am aware I may consult with an attorney prior to executing this Waiver of Liability and Release Agreement, that I voluntarily have signed the same and that I have read and understand this Waiver of Liability and Release Agreement. **I FULLY UNDERSTAND THAT, BY SIGNING THIS WAIVER OF LIABILITY AND RELEASE AGREEMENT, I AM WAIVING IMPORTANT LEGAL RIGHTS.**

IN WITNESS WHEREOF, I have signed this Waiver of Liability and Release Agreement this ____ day of _____, 2022.

Witness:

Signature: _____

Print Name: _____

Date: _____

Patient:

Signature: _____

Print Name: _____

Date: _____

Parent's/Guardian's Signature (if Patient is under 18): The undersigned is a parent(s) or legal guardian(s) of the Patient and hereby consents to the foregoing Waiver of Liability and agrees (1) on behalf of the Patient for Patient to be bound by the provisions hereof and (2) on behalf of himself or herself and each other parent or guardian of the Patient, that all of the terms hereof, including all liability waived hereby, equally apply to and they are subject to each of them.

Signature: _____

Print Name: _____

Date: _____

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Have you been fully vaccinated? (Fourteen days after second dose)	☐	☐
If yes, and if you would like to be exempt from this covid screening in the future are we able to put a copy of your vaccine card on file? (If no, no worries **BUT** we will have to complete this screening every visit per Dr. Le following CDC protocol)	☐	☐
Have you traveled outside / within the United States by air in the past 14 days? (Public transportation: plane, cruise, bus or train)	☐	☐
If yes, when did you return to the State of Texas? X_____		
Do you have any COVID symptoms as followed? (Runny nose, dry cough, sore throat, loss of sense of smell, high temperature or trouble breathing)	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ Signature

_____ Date

_____ Witness

_____ Patient Temperature