**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

Date: _____ 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: _____

**In case of emergency**: _____ _____
Name phone number

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: _____ Address: _____

Cell #: _____ Email: _____ Reason for visit: _____

**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
- ☐ 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
- ☐ Pregnancy
  Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ 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: _____
- Have you ever been pre-medicated with antibiotics before dental treatment? ☐ 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 DDS

## 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 Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

**Witness Signature**

Date Time

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# Appreciated Patient Letter

This year marks the beginning of many exciting changes in my office in my effort to improve service and quality of care for you so that you can regain and maintain your health as quickly, efficiently and inexpensively as possible.

I have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional and ethical responsibility to care for your health to the best of my ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you.

If you cannot keep your appointments and adhere to my treatment recommendations, I will not be able to continue treating you in good conscience.

Therefore, the following policies must be agreed upon:

No-shows are not acceptable; Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. **There is a $75.00 fee for all no-show appointments or appointments not canceled 48 business day hours in advance and this fee is not covered by insurance.** This money will be donated to Clothes Closet of Mansfield.

Timeliness is required; we will see you on time and get you out on time unless there is an emergency.
We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves. We request that you brush your teeth prior to being seated in a treatment room. Toothbrushes, paste, mouth rinse and floss will be provided for you if needed.

If you miss an appointment you must make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

Insurance- Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being – we are. We will provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.

We run a Zero Balance office; we expect payment in full prior to or at the time treatment is provided. We have several financial options available for all of our patients. Please speak to our financial coordinator if you have any questions.

**In order to schedule a treatment appointment with Dr. Le, we require at least 50% of the total patient out-of-pocket expense as a deposit and a signed financial agreement.**

Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.

Upsets- It is our company policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you should an upset occur provided you bring it to our attention in an appropriate, cordial manner at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that my staff will treat you with the same professional demeanor and efficiency, as you would expect from them. Please see our Patient Relation Coordinator to resolve immediately any upsets you may have with my office or one of my team.

Emergencies- It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this we would like to define what a true emergency is. Swelling, bleeding and severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

I greatly appreciate your cooperation.

Yours in Health,

Dr. Kim Le

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Office Signature Date

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# Financial Policy

Thank you for choosing our office as your dental health care provider. Our primary responsibility is to deliver the best and most comprehensive dental care available. Part of our commitment is your understanding and responsibility for the payment of your account balance.

**Full payment is due at the time of service unless other arrangements have been made with our office.**

We accept CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND CARE CREDIT.

## Adult Patients

Adult patients are responsible for full payment at the time of service unless specific arrangements are made prior to the start of treatment.

## Minor Patients

The adult accompanying a minor and the parents/guardians are responsible for full payment at time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to by Visa/MasterCard or by cash; check at time of service has been verified.

## Regarding Insurance

Full payment is required at time of service, we will accept assignment of participating insurance plans and will submit dental claims on our patient's behalf, and we will submit a refund for payment from an insurance company back to our patients in a timely fashion. A pre-treatment estimate will need to be submitted to your insurance company to determine the schedule of benefits for the services to be rendered.

*Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Any insurance claim not settled within 45 days will be due in full. It's your responsibility to pay our practice in full for the treatment invoice.*

*Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider.*

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Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have you receive the maximum insurance benefits you are entitled to.

Patient Responsibility and Additional Terms

Accounts unpaid after 60 days from day of service are subject to a delinquent fee of $35.00. Furthermore the unpaid balance is subject to a 1½% monthly (18% annual) finance charge. If we have to submit your unpaid account to a collections process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fees.

**Missed or Late Appointments/Returned Checks**

**Unless appointments are cancelled at least 48 business day hours in advanced our policy is to charge for missed appointments. You will be charged a $75.00 non-refundable fee for all appointments canceled within 48 business hours of appointment time or if you do not show to your scheduled appointment time**.

**Showing up 15 minutes late after your scheduled appointment time will possibly result in us needing to reschedule your appointment due to the courtesy of other patients.**

Any returned check will carry a $40.00 fee.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

***I have read and I agree to the terms of this financial policy.***

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Co-Responsible Party Signature Date