Marly J. Gomes, D.M.D.
Stephanie Leung, D.M.D.
49 State Road, Dartmouth Place
Nauset Building, Suite 101
Dartmouth, MA 02747

Patient Information Form

Name (First, Middle, Last)	Sex	Date of Birth	Social Security Number
Permanent Address (Street)	Marital Status	Date	E-mail Address
City, State & Zip	Spouse's or Parent's Name, Date of Birth		
Home Phone: Work Phone: Cell Phone:	Spouse's Employer		
Employer	Spouse's Dental Insurance co.		
Dental Insurance Co. Group Number	Spouse's Social Security Number		
Occupation	Spouse's Work Phone Number		
Previous Dentist	Who may we contact in an emergency?		
Last visit to the dentist	Emergency contact phone number		
Reason for this visit	Who referred you to this office?		

Please indicate payment method ____ Cash ____Credit Card ____Check

Signed_____

(Patient or Responsible Party)

Marly J. Gomes, D.M.D.
Stephanie Leung, D.M.D.

Financial Policy

For Patients With Insurance

Our practice is committed to providing the best treatment possible for our patients. Our fees are usual and customary for treatment provided. As a courtesy to our patients with insurance, we will file your dental & or medical claims for services rendered. You are responsible for paying any deductible and co-payment at the time of service. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as we estimate. Any amount not paid by insurance is your responsibility. We will be happy to file a pre-determination to the insurance company so we can get a more accurate estimate of what they should pay, but it is still not a guarantee of their payment. Once we receive payment from the insurance company, you will be required to pay the balance due upon receipt of your statement. The balance due for services provided is the patient's responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you will receive a refund. Refund checks are processed monthly.

ATTENTION MEDICAID PATIENTS: Medicaid does not cover all dental procedures, so payment is due in full at the time of service.

For Patients Without Insurance

FULL PAYMENT IS DUE AT TIME OF SERVICE. Our office gladly accepts Visa, MasterCard, Discover, Cash, Checks, and Care Credit. If you would like to apply for Care Credit financing, please consult our front office staff.

Delinquent Accounts

In order to keep costs down for all patients, extended payment plans are subject to late charges of 1½ % per month. We reserve and will exercise the right to report any account 90 days past due to a Collection Agency. The patient agrees that all costs of delinquent account collection, including attorney's fees, will be the responsibility of the patient, as permitted by law.

Cancellations & Missed Appointments

Appointments are valuable blocks of time and when an appointment is broken or cancelled with short notice, we are often prevented from filling that time and helping other patients. Please give at least ***24 hours notice*** when you will not be able to make your scheduled appointment. This will allow us time to help other patients and helps keep costs down. There may be a charge for all consultation and surgery appointments broken or cancelled with less than the required 24 hour notice. Additionally, if you are more than 15 minutes late for an appointment, you may have to be rescheduled.

Authorization for Treatment

I authorize Marly J. Gomes, D.M.D., Stephanie Leung, D.M.D. and staff to perform mutually agreed upon dental procedures and administer such anesthetics as found necessary to treat the dental condition of the above named patient. I understand and agree to the office policies outlined above, and I certify that the above information is correct to the best of my knowledge.

By signing below, I certify I have read, understand, and agree to this financial Policy.

Patient Signature_____ Today's Date_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

Address _____

Telephone _____ E-mail _____

Patient # _____ Social Security # _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Receptionist

Telephone: 508 999-2234 Fax. _____

E-mail: info@gomesdentistry.com

Address: 49 State Road, Ste. 101, Nauset Bldg., Dartmouth, MA 02747

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

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info@gomesdentistry.com

Broken Appointment / Cancellation Policy

In Order to provide the highest quality care to our patients, we have established a formal "Broken Appointment/ Cancellation Policy". This is intended to increase productivity and to improve timely access to all patients, to reduce / eliminate empty slots in the appointment schedule.

We understand that there may be circumstances that require you to cancel and appointment, but we require that you notify our office no less than 24 hours in advance.

Your appointment time has been reserved for you, and if you do not keep it, this results in being wasted time for other patients who could have been seen as well as for our staff. This is not fair to anyone.

When you break an appointment, the failure to keep your scheduled appointment is documented. This will result in your not being rescheduled.

DEFINITIONS:

BROKEN APPOINTMENTS occur when a patient:
- -makes an appointment then fails to keep the appointment
- -forgets to cancel the appointment
- -neglects to cancel the appointment 24 hours prior to the scheduled time

CANCELLATION occurs when a patient contacts the office and provides a 24 hour notification prior to the appointment that they cannot keep the appointment.

APPOINTMENT CONFIRMATION PROCEDURE

Unable to Contact by Telephone
In the event you are unable to provide a telephone contact number, **it will be your responsibility to call our office (508) 999-2234 at least 24 hours prior** to your scheduled appointment time to confirm. If you do not contact our office your appointment will be cancelled.

48 Hour Friendly Reminder Telephone Confirmation-ALL patients
A representative of our staff will telephone you 48 hours prior to your scheduled appointment as a friendly reminder.

I _____ understand and agree to the office policies outlined above.
Signature of Patient/Legal Guardian

Date: _____