Amaze Dental

DeSoto & Cedar Hill Dentist

PATIENT INFORMATION

Name _____
Last *First* *M.I.* *Preferred Name*

Gender: M F Marital Status: _____SSN:_____ DOB:_____

Driver's License#: _____E-mail Address: _____

Patient Address_____
Street *City* *State* *Zip*

Home Phone #: _____Work: _____Ext:_____Other:_____

Which is best for confirmation? E-MAIL _____Home#_____Work#_____Cell#_____

Who may we thank for referring you to our practice?_____

Emergency Contact : _____
Name *Phone #*

RESPONSIBLE PARTY INFORMATION (If Different From Above)

Name _____
Last *First* *M.I .* *Preferred Name*

Gender: M F Marital Status: _____ SSN: _____ DOB:_____

Driver's License #: _____E-mail Address: _____

Patient Address_____
Street *City* *State* *Zip*

Home Phone #: _____Work:_____Ext:_____Other:_____

Dental Insurance (If any)
Insurance Company _____ Insurance Phone: _____

Subscriber's Name :_____ DOB: _____

SSN or I.D.# _____Relationship to Patient : _____

Subscriber's Employer :_____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s) have insurance coverage with _____and assign directly to Amaze Dental –Desoto and Cedar Hill Dentist and its affiliates all insurance benefits, if any , otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not they are paid for by insurance. I authorize the use of my signature on all insurance submissions. Please be advised that due to nature of our business, we require a 48-hour cancellation notice. The above named office and /or doctor may use my health care information and may disclose such information to the above named insurance and company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and balance is paid-in-full or two years from the date signed below.

_____ _____ _____
Signature of Patient/Parent or Guardian Please print name of Patient/ Parent or Guardian Date

MEDICAL HISTORY

NAME ____ _____ BIRTHDATE _____
Physician's Name _____ Phone _____
Address _____
Are you currently under the care of a physician? ☐ Yes ☐ No
If Yes, for what reason? _____
Please list all of the medications that you are taking in the box to the right →→→→→→
Have you ever taken prescription drugs for weight loss (i.e. PhenFen or Redux)? ☐ Yes ☐ No
Have you ever taken medications for Osteoporosis (i.e. Fosomax, Aredia, Boniva? ☐ Yes ☐ No
Are you, or have you ever taken any "Blood Thinners" (i.e. Coumadin, Plavix) ☐ Yes ☐ No
Do you currently, or have you had to, take antibiotics before dental treatment? ☐ Yes ☐ No

List **ALL** medications including prescription, over-the-counter, vitamins and supplements:

ALLERGIES

Are you allergic (or have an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ None
☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances

Are you sensitive or allergic to latex? (Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon) ☐ Yes ☐ No
Have you had any unusual or unexplained reactions during a surgical procedure? ☐ Yes ☐ No Explain: _____
Hearing impaired? ☐ Yes ☐ No

Do you have, or have you ever had any of the following. (Yes or No)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	☐	☐	Asthma	☐	☐	Artificial Joint	☐	☐	Hepatitis (check one)	☐	☐
Heart Murmur	☐	☐	Shortness of Breath	☐	☐	Prosthetic Implants	☐	☐	Type: ☐ A ☐ B ☐ C		
Heart pacemaker	☐	☐	Respiratory Ailments	☐	☐	Cancer	☐	☐	Ulcers	☐	☐
Rheumatic fever	☐	☐	Tuberculosis	☐	☐	Radiation Therapy	☐	☐	Stomach Disorders	☐	☐
Rheumatic heart disease	☐	☐	Sinus Trouble	☐	☐	Chemotherapy	☐	☐	Organ Transplant	☐	☐
Congenital heart disease	☐	☐	Chronic Cough	☐	☐	Prolonged Bleeding	☐	☐	Glaucoma	☐	☐
Artificial heart valve	☐	☐	Thyroid Problems	☐	☐	Leukemia	☐	☐	Cortisone medicine	☐	☐
Mitral valve prolapse	☐	☐	Kidney Problems	☐	☐	Blood Disorders	☐	☐	Arthritis/Rheumatism	☐	☐
High Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐	Hemophilia	☐	☐	Neurological disorders	☐	☐
Low Blood Pressure	☐	☐	HIV positive/AIDS/ARC	☐	☐	Anemia	☐	☐	Epilepsy	☐	☐
Sleep disorders	☐	☐	Stroke	☐	☐	GERD (gastric reflux)	☐	☐	Osteoporosis	☐	☐
Sleep Apnea	☐	☐	Fainting Spells	☐	☐	Removal of spleen	☐	☐	Blood Transfusion	☐	☐
Diabetes	☐	☐	Anorexia/Bulimia	☐	☐	Liver disease	☐	☐			

DR COMMENTS:

☐ **Premedication Required** _____

Do you currently smoke or use the following tobacco products?
☐ Cigarette Packs/Day? ____ ☐ Cigars ☐ Pipe ☐ Chew ☐ None

Have you used tobacco products in the past? ☐ Yes ☐ No How long ago? _____

WOMEN: Are you pregnant? ☐ Yes ☐ No
Do you take any birth control medications? ☐ Yes ☐ No
If yes, please note: _____

Have you had any other serious illness, hospitalization or accident?
If yes, please explain _____

Would you like to speak to the doctor privately about any problem? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of my changes in my health or medication.

Patient's Signature _____ Date _____
(PARENT/GUARDIAN OF A MINOR)

DENTAL HISTORY

What is the Reason for Your Visit Today? _____

Previous Dentist's Name _____ Address _____

Date of Last Visit _____ Last Hygiene (Cleaning) Visit _____ Last X-Rays _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (Electric toothbrush, toothpick, etc) _____

Are any of your teeth sensitive to:

Hot or Cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or pressure?	☐ Yes	☐ No
Have you ever noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any lesions?	☐ Yes	☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught between your teeth?	☐ Yes	☐ No

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe)	☐ Yes	☐ No
Mouth breathe while asleep or awake?	☐ Yes	☐ No
Snore?	☐ Yes	☐ No
Do you use a CPAP machine?	☐ Yes	☐ No

Have you ever experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain? (Joint, ear, side of face)	☐ Yes	☐ No
Difficulty opening or closing the mouth?	☐ Yes	☐ No
Frequent headaches, neck aches, or shoulder aches?	☐ Yes	☐ No
Any pain or soreness in the muscles of your face or around the ears?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral Surgery?	☐ Yes	☐ No
Teeth removed?	☐ Yes	☐ No
If so, have they been replaced	☐ Yes	☐ No
Are you happy with their replacement?	☐ Yes	☐ No
Removable Partial?	☐ Yes	☐ No
Complete Denture?	☐ Yes	☐ No
Fixed Bridge?	☐ Yes	☐ No
Implants?	☐ Yes	☐ No
Periodontal Treatment?	☐ Yes	☐ No
Gum Surgery?	☐ Yes	☐ No

If so, when? _____

By whom? _____

Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A serious injury to the head or jaws?	☐ Yes	☐ No

If so, please describe. Include cause

_____

_____

Do you like the appearance of your teeth/smile?	☐ Yes	☐ No
Do you like the color of your teeth?	☐ Yes	☐ No
Are your teeth as straight as you would like?	☐ Yes	☐ No

What would you like to change most in the appearance of your teeth?

_____

_____

Do you feel anxiety about having dental treatment? ☐ Yes ☐ No

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, please describe,

_____

How did you overcome your anxiety?

_____

Is there anything else about having dental treatment that you would like us to know? Please describe _____

_____

_____

Do you have any other dental problems? ☐ Yes ☐ No

If yes, please describe _____

I consent to the doctor's examination and necessary diagnostics for treatment including X-rays

Patient Signature _____ Date_____

(PARENT/GUARDIAN OF A MINOR)

Reviewed by_____ Date_____

CONSENT TO PERFORM DENTISRY

1. I hereby authorize and direct the dentist(s) of Amaze Dental -DeSoto and Cedar Hill Dentist and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

- Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
- Application of plastic "sealants" to the grooves of the teeth.
- Treatment of diseased or injured death with dental restorations (fillings and crowns).
- Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
- Removal (extraction) of one or more teeth.
- Treatment of diseased or injured oral tissues (hard and/or soft).
- Use of sedative drugs to control apprehension and/ or disruptive behavior.
- Treatment of malposed (crooked) teeth and/ or oral developmental or growth abnormalities.
- Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/ or parents of the patient follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/ her auxiliaries must be maintained.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well-being, in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue. Allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of the breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also ware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

7. I hereby authorize state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

8. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name**:**_____

Name of Parent/Guardian:_____ Relationship to Patient:_____

Patient/Parent/Guardian Signature: _____

Date:_____ Time:_____ AM/PM

Witness:_____

Amaze Dental
DeSoto & Cedar Hill Dentist

Appointments

_____ Our patients are seen by appointments. When an appointment is made, doctor time and treatment room is reserved specifically for that appointment. Our office will begin calling you two days prior to your appointment to confirm the time. It is our policy that we must speak to you or a parent if the patient is a minor. If a message is left, you must call back 24 hours prior to the appointment to secure your appointment in our office. We will allow messages to be left on our recorder confirming the time if it's after hours.

Insurance

_____Your insurance coverage is a contract between you and your insurance carrier. Our office verifies all insurance coverage and accept assignment of benefits as a courtesy to our patients. We are only able to provide you with an estimate of your benefits based on information received from your insurance company. In the event that your insurance company does not pay their estimated portion of your treatment, you are responsible for payment.

_____ Your deductible, co-pay, and any portion of your treatment not covered by insurance, is due and payable at the time of service. After each appointment, you will receive a walkout statement outlining the charges for that appointment, and any payments made. After our office has received final payment from your insurance company for your treatment, you will be billed for any unpaid balance remaining on your account.

_____ Regardless of insurance status, you are responsible for payment of all treatment fees (covered or non-covered) and any cost, legal or otherwise, which are incurred in the collection of your account balance should become delinquent.

Privacy Notice

_____ I acknowledge that I have been given the opportunity to review and receive a copy of the privacy notice.

Payment of fees

_____ Payment for professional services is due at the time service is rendered, unless you have made prior written arrangements. Payments may be made in the form of cash, check, American Express, Discover, Visa or MasterCard. By signing below, you are accepting responsibility for the payment of any charge incurred in your treatment.

Payment Plan

_____ We do offer financial help through Care Credit.

Responsible Party Name _____ Signature _____ Date _____

Amaze Dental-Desoto and Cedar Hill Dentist

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. ABOUT US

Amaze Dental-Desoto and Cedar Hill Dentist is committed to maintaining your health information. In this notice, we use terms like "we," "us" or "our" to refer to Comfort Smile Dental. and its participating dentists, employees, staff, and other office personnel.
OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your "protected health information." We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including protected health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. We will post a copy of the then current Notice at our offices.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose your protected health information about you for treatment, payment, and healthcare operations.

Protected Health Information: "Protected health information" or "PHI" for short, is information that identifies you and relates to, your past, present or future physical or mental health or condition, the provision of healthcare to you, or past, present, or future payment for the provision of healthcare to you. PHI does not include information about you that is publicly available, or that is in summary form that does not identify who you are.

Protection of PHI: We restrict access of your PHI to those employees who need access to provide services to our patients. We have established and maintain appropriate physical, electronic, and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees and contracted personnel must complete and update from time to time. We have established a Privacy Office, which has overall responsibility for developing, training and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use and disclosure.

Treatment: We may use or disclose your PHI to a dentist, orthodontist, periodontist, physician, or other healthcare provider providing treatment to you. For example, we may use your PHI to other specialists who may provide care to you. Your dentist may use your medical and dental history to decide what treatment is best for you. We may also disclose your PHI to recommend to you other treatment alternatives.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. For example, we may need to give your insurance company PHI about a service you received so your plan will pay us or reimburse you for the service.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities. For example, we may use your PHI to evaluate the performance of our staff in caring for you.

Business Associates: We may disclose your PHI to Business Associates independent of the practice with whom we contract or arrange to provide services on your behalf. However, we will only make such disclosures if we have received satisfactory assurances that the Business Associate will properly safeguard your privacy and the confidentiality of your PHI. For example, we may contract with a company outside of the practice to provide transcription services for the practice or collection of reviews so we can improve our care or collection services for past due accounts. This company would be considered our Business Associate.

Your Authorization: In addition to our use of your PHI for treatment, payment, or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section of this notice. We may disclose your PHI to a family member, close friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. We may also disclose PHI to your family or friends if we can infer from the circumstances, based upon our professional judgment that you would not object. For example, we may assume that you agree to our disclosure of your PHI to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays. You, as a parent, can generally control your minor child's PHI.

Persons Involved in Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization.

Required by Law: We may use or disclose your PHI when we are required to do so by law and for other purposes permitted by applicable law such as, for public health activities, reports to coroners, medical examiners, or funeral directors, to avert a service threat to the health or safety of you or other members of the public or for law enforcement purposes, all as set forth in the Privacy Rules.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances.

Other Situations Where Disclosure May or May Not Require Your Consent: We may also use or disclose your PHI as follows: (I) for worker's compensation or similar programs providing benefits for work-related injuries or illness as authorized by state laws, or (ii) if you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. Except as may be prohibited by law, we also disclose PHI about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you or your attorney about the request or to obtain an order protecting the information requested.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, postcards, e-mail, or letters). This may be done through an automated system or by one of our staff members. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the telephone. Please contact us if you wish to limit the manner in which we can contact you.

PATIENT RIGHTS Access: You have the right to inspect, look at, or get copies of your PHI, except as prohibited by law. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access during normal business hours by sending us a letter to the address at the end of this Notice. We reserve the right to charge a reasonable administrative fee for copying your PHI. We may deny your request to inspect and copy in certain circumstances. If we deny your request for review or copy of your PHI, we will explain the reason in writing.

If we do not have your PHI, but know who does, we will tell you whom to contact. If you are denied access to certain protected health information, to the extent required by applicable law, you may request that the denial be reviewed. Some types of records may be denied to you and no review is allowed, such as information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If applicable law requires such review, another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Disclosure Accounting: Once every 12 months, you have the right to receive a free list of instances in which we or our Business Associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but may not include dates before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will respond to your request within a reasonable period, but no later than 60 days after we receive your written request; provided, however, that we may extend the 60-day period for an additional 30 days.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for it. All such requests must be in writing. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Your PHI is critical for providing you with quality care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI, and that additional restrictions may be harmful to your care.

Alternative Communication: You have the right to request that we communicate with you about your PHI in a confidential manner. For example, you may request that we send your PHI by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will accommodate reasonable requests, unless they are administratively too burdensome or prohibited by law.

Amendment: You have the right to request that we amend your PHI. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances, including the failure to make such request in a writing or a writing that does not support the request. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Secretary of the U.S. Department of Health and Human Services or us. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

For further questions, please contact us@
216 Dalton Dr
DeSoto
TX 75115
PH # 972-230-1100
Email: info@amazedentaldesoto.com

Financial Policy

Amaze Dental -Desoto and Cedar Hill Dentist is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time.

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **All patients must complete our Patient Information Form before seeing the dental professional.**
- **Full payment is due at time of service.**
- **We accept cash, checks, American Express®, VISA®, MasterCard®, Discover® and CareCredit®.**
- **Amaze Dental – DeSoto and Cedar Hill Dentist provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service.**

Adult Patients

Adult patients are responsible for full payment at time of service.

Minors Accompanies By an Adult

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

Unaccompanied Minors

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to American Express, VISA, MasterCard or Discover.

Insurance

Amaze Dental -Desoto and Cedar Hill Dentist provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Amaze Dental -Desoto and Cedar Hill Dentist staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Amaze Dental -Desoto and Cedar Hill Dentist. However, if you are paid by the insurance company instead of Amaze Dental -Desoto and Cedar Hill Dentist, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are always responsible for any charges that are not covered by your insurance.

Financial Policy

Medicare/Medicaid/Workers' Compensation

If you are covered by Medicare, Medicaid, Workers' Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to date of service.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

Missed Appointments

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Amaze Dental -DeSoto and Cedar Hill Dentist complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Amaze Dental -DeSoto and Cedar Hill Dentist does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Amaze Dental -DeSoto and Cedar Hill Dentist:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- ○ Qualified sign language interpreters
- ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- ○ Qualified interpreters
- ○ Information written in other languages

If you need these services, contact Stephanie

If you believe that Amaze Dental -DeSoto and Cedar Hill Dentist has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Deepti Namineni , 216 Dalton Dr ,DeSoto TX 75115. Ph# 972-230-1100. Fax: 972-230-1103 Email: info@amazedentaldesoto.com.
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Deepti Namineni is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Texas

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spanish:
Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio odontológico que suministramos.

Vietnamese:
Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Chinese:
我们将有序地做到提供免费的语言服务使我们能听懂英语不好的人向我们咨询有关牙齿护理

Korean:
저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

Arabic:
سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق برعاية الأسنان التي نقدمها.

Urdu:
ہم ان لوگوں کو جو ہماری پیش کردہ زبان بولتے ہیں لیکن انگریز ی نہیں جانتے اور ہم سے ڈینٹل کیر کے لیے بات کرتے ہیں مفت زبان دانی کی امداد کے لیے معقول اقدام اٹھائیں گے۔

Tagalog:
Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

French:
Nous prendrons les mesures raisonnables pour fournir des services d'assistance linguistique gratuits pour les individus qui parlent des langues que nous sommes susceptibles d'entendre durant nos séances et qui ne parlent pas suffisamment bien l'anglais pour discuter avec nous concernant les soins dentaires que nous fournissons.

Hindi:
हम उन व्यक्तियों को, जो कि ऐसी भाषाएं बोलते हैं जो हम अपने अभ्यास में संभावित रूप में सुनना चाहते हैं और जो हमारे द्वारा प्रदान की जाने वाली डैंटल देखभाल के बारे में हमारे साथ उचित ढंग से अंग्रेज़ी नहीं बोलते, मुफ़्त सेवाएं प्रदान करने के लिये उचित कदम उठायेंगे।

Persian (Farsi):

ما برای ارائه خدمات ترجمه رایگان به افرادی که زبان انگلیسی آنها برای صحبت با ما درباره خدمات مراقب از دندان ارایه شده ما در حد کافی نبوده و به زبان های صحبت می کنند که ما به احتمال زیاد در هنگام کار با آنها سر و کار پیدا می کنیم گام هایی منطقی را بر خواهیم داشت.

German:

Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Gujarati:

અમે એવા લોકોને વિના મૂલ્યે ભાષા સહાય સેવા પૂરી પાડવા ઉચિત પગલાં લઇશું

જેઓ એ ભાષાઓ બોલે છે જે અમને (તબીબી) પ્રેકટીસમાં સાંભળવા મળી શકે અને

જેઓ અમે જે દંત સુરક્ષા પ્રદાન કરીએ છીએ તેના વિષે વાત કરવા પૂરતું યોગ્ય ઇંગ્લીશ બોલી શકતા નથી.

Russian:

Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

Japanese:

実際に練習の中で耳にするく可能性がある言語を話す人々で、弊社が提供している歯科治療について、英語がそれほど上手でない人々に、無償の言語支援サービスを提供するために合理的な措置を講じるつもりです。

Laotian:

ພວກເຮົາຈະໃຊ້ຂັ້ນຕອນທີ່ເໝາະສົມ
ເພື່ອໃຫ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າແກ້ຄົນຜູ້ທີ່ເວົ້າພາສາທີ່ພວກເຮົາອາດຈະໄດ້ຍິນຢູ່ໃນການຝຶກຊ້ອມຂອງພວກເ
ຮົາ ແລະ ຜູ້ທີ່ບໍ່ເວົ້າພາສາອັງກິດໄດ້ດີພໍ ເພື່ອລົມກັບພວກເຮົາກ່ຽວກັບການບໍ່ງແຍງດູແລແຂ້ວທີ່ພວກເຮົາກຳລັງຈັດໃຫ້.