Hadley Family Dentistry
5406 S Emerson Ave, Indianapolis, IN 46237
(317) 780 7777
www.hadleydentistry.com

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature:

Date:

Hadley Family Dentistry
5406 S Emerson Ave, Indianapolis, IN 46237
(317) 780 7777
www.hadleydentistry.com

PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

Hadley Family Dentistry
5406 S Emerson Ave, Indianapolis, IN 46237
(317) 780 7777
www.hadleydentistry.com

FINANCIAL POLICY

In our continued commitment to providing the highest quality dental care available, we are pleased to let you know that we offer multiple forms of payment. We accept Cash, Visa, MasterCard, Discover, American Express, and Care Credit.

We are committed to supporting you in understanding your dental health so that you will always be able to make the best choices.

INSURANCE

We understand that processing dental insurance can be a time-consuming and complicated task. As an added benefit of using HadleyFamily Dentistry, we will be glad to process your dental insurance benefits for you.

If you have dental insurance, we accept assignment of insurance benefits after co-payments and deductibles are met.
You are fully responsible for the total payment of all procedures performed in this office; this includes any treatment that is not a benefit of any dental insurance that you may have. Payment is due in full within 30 days of service. Your insurance is a contract between you and your insurance company and their payments should be monitored by you for timely payment.

If you do not have dental insurance, our office will extend a 10% discount on services rendered that are paid in full at the time of the initial appointment.

Payment is due at the time of service.

Any payment arrangements must be made prior to treatment.

MONTHLY BILLING CHARGES

Monthly statements will be forwarded to you for the fees you are responsible for. All payments are due as indicated on the statement.Any payments made after the due date are considered late and will incur additional billing fees monthly.

Balances over sixty (60) days will incur a $5.00 monthly billing charge.

There is a $40.00 fee for all NSF checks returned to Hadley Family Dentistry.

All delinquent accounts will be forwarded for collection. Any refiling fees, collection charges, court costs, and reasonable attorney fees will be added to an overdue balance.

MISSED APPOINTMENTS & CANCELLATION POLICY

A fee of $50.00 will be charged for the following:
- Missing your appointment
- Rescheduling within 48 hours of your appointment
- Arriving late to your appointment requiring your treatment needs to be rescheduled.

Appointment times are reserved especially for you and our team spends extensive amounts of time preparing for your visit. Broken and missed appointments prevent other patients from receiving the care that they need. If you find that you must change your appointment, we kindly ask for a minimum of 48 hours notice so that we may accommodate other patients.

CONSENT FOR TREATMENT

I, the undersigned hereby authorize any doctors employed by Hadley Family Dentistry, Inc. or designated sta? members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a comprehensive diagnosis of existing conditions. I further authorize any doctors employed by Hadley Family Dentistry, Inc. or designated sta? members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I also assign all insurance benefits to Hadley Family Dentistry, Inc

Patient's signature: Date:

Hadley Family Dentistry
5406 S Emerson Ave, Indianapolis, IN 46237
(317) 780 7777
www.hadleydentistry.com

COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Hadley Family Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Hadley Family Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Hadley Family Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Hadley Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Hadley Family Dentistry.

Patient's signature: Date:

Hadley Family Dentistry
5406 S Emerson Ave, Indianapolis, IN 46237
(317) 780 7777
www.hadleydentistry.com

TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Hadley Family Dentistry, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Hadley Family Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Hadley Family Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Hadley Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Hadley Family Dentistry.

Patient's signature: Date: