# Dr. Frederick Stange and Associates

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## Welcome to our Practice

We are delighted to welcome you to our practice and are pleased that you have chosen us to care for your dental needs. We will do our utmost to maintain an environment of trust and professionalism where you will feel welcome, well cared for and well informed.

Professionally, we have been serving the dental needs of patients in the New York City area for more than fifteen years and are very excited to share with you the best that dentistry has to offer today. We are confident in the services provided at our office. Our materials, equipment and sterilization techniques represent state of the art technology. Most importantly, we are sensitive to our patients' feelings and encourage open communication about your dental care.

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** _____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

## Employment Information

**The following is for:** ○ the patient ○ the person responsible for payment ○ both ○ not applicable

**Employer Name:** _____ **Phone:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

How did you hear about our practice?

_____

**In an emergency who should be notified? Please enter Name and Phone number below:**

_____

_____

## Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

**The following is for:** ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

**Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** ___-__-____ **DL#:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

### Primary Dental Insurance:

**Name of Insured:** _____ _____ ___
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:** ○ Self ○ Spouse ○ Child ○ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

**Insurance Company Phone Number:**

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## Insurance Authorization:

☐ **By checking this box,**
**I authorize my insurance company to pay the dentist all insurance benefits rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges whether or not paid by insurance.**

## Consent for Services and Financial Policy

Please understand that the amount of coverage you have is based on the type of policy and the benefit amount your employer has selected to fund.

We will file your insurance claims as a courtesy for you. Regardless of what we may calculate your insurance company to pay, it is only an estimate. The financial obligation for dental treatment is between you and this office, and its not between this office and your insurance company.

We will do all we can to get the maximum benefits reimbursed for you. Please be aware that some of the services provided may not be covered or may be considered above the "usual and customary". You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of "usual and customary" fees.

When our professional services are rendered, you are responsible for payment at the time of treatment unless prior arrangements have been made with our financial coordinator. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment options.

**We accept the following payment types:**

○ 1. Cash or Check

○ 2. Visa/Mastercard/American Express/Discover/Debit Checking Card/ Apple Pay

○ 3. Care Credit Finance Option (must be pre-approved)

In the event that payment is not made and legal action is required, the patient shall be responsible for all legal fees, court costs and interest accumulation from the date of completion at 1% per month.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

## Informed Consent in the Era of Covid-19

Thank you for your trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in

our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dentists staff and sometimes other patients at all times.

**Although exposure is unlikely, do you accept the risk and consent to treatment? *** ○ Yes ○ No

## Cancellation Policy

We realize that occasionally things do occur that create changes in schedules, but ask that you please give us 2 Business Days Notice (excluding weekends) if the need to reschedule your appointment should arise. This will avoid a charge and will allow us to offer this time to another patient. With this notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you. Unless an emergency occurs, you can expect us to be on time. We appreciate you being prompt also.

Please let us know if you have any questions or concerns. We are here to make your experience as pleasant as possible.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.**

## HIPAA Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);
The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice Of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time, However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

## Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to

immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

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**Response Date:** _____