Frederick A. Stange, DDS
And Associates
210 East 47th Street
New York, NY 10017
212-888-3570

Welcome

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.

Finances

Our office understands the value of insurance benefits to our patients, therefore, we will be happy to complete and file your insurance forms at no charge.

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.

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.

Please ***Circle*** below the form of payment you wish to choose to settle your account.

(1) Cash or Check
(2) Visa / Mastercard / American Express / Discover / Debit Checking Card
(3) Care Credit

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.

Appointments

We realize that occasionally things do occur that create changes in schedules, but ask that you please give us 48 hours 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 your 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.

Signature of patient responsible: _____

Date: _____

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Patient Consent Form

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.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____