PATIENT REGISTRATION

Patient Information

First Name: ______________________________ Last Name: ____________________________________ M.I.: ________

Address: ____

City, State, Zip: ____

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: _______________________

Sex (please circle): Male / Female Marital Status (please circle): Married / Single / Divorced / Widowed

Date of Birth: _____________________ Age: ________ Social Security: ____________________ D.L. #: _____________

Email: ____

Employment Status (please circle): Full Time / Part Time / Retired Student Status (please circle): Full time / Part time

How did you hear about our office: ____

Responsible Party (if someone other than the patient/parent if patient under 18)

First Name: ______________________________ Last Name: ____________________________________ M.I.: ________

Address: ____

City, State, Zip: ____

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: _______________________

Date of Birth: ______________________________ Social Sec: _______________________ D. L. #: ____________________

Relationship to Patient: ____

Insurance Information

Name of Primary Insured: ____ Insured Date of Birth: ______________

Relationship to patient (please circle): Self / Spouse / Child / Other

Insured Social Security #: _________________________ Insured Employer: _____________________________________

Insurance Company: ____ Insurance Contact #: ______________________

Insured ID #: ______________________ Group #: _________________________

Secondary Insurance (if applicable)

Name of Primary Insured: ____ Insured Date of Birth: ______________

Relationship to patient (please circle): Self / Spouse / Child / Other

Insured Social Security #: _________________________ Insured Employer: _____________________________________

Insurance Company: ____ Insurance Contact #: ______________________

Insured ID #: ______________________ Group #: _________________________

Appointment Policy

Our staff strives to provide the quality of care that we feel each of our patients deserve. When we schedule your appointments, we follow carefully planned protocols to reach this goal. As a courtesy, our staff will call at least 48 hours in advance to confirm each of your appointments. If we are not able to reach you or you receive a voicemail, please call our office to verbally confirm you appointment time. This will help us be better prepared for your arrival.
Please understand that we may not be able to hold your appointment time if we are unable to confirm your appointment.

We do respect our patient's schedules and we ask that you would also have respect for our schedule and the schedules of others. Late arrivals cause us to run late for other patients. Please understand that arriving after your appointment time may result in the rescheduling of your appointment. We do understand that unexpected events and emergencies can happen. Please let the office know as soon as possible that you can not make your appointment time. If your new appointment request does not interfere with another patient's schedule, we will be happy to accommodate you.

We do ask for 48 hours notice to reschedule or cancel an appointment. Multiple rescheduled or cancelled appointments may result in additional charges that would need to be paid prior to scheduling future appointments.

Thank you for your understanding and the understanding of others.

Patient signature: ___________________________________

Date: ____/____/____

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect immediately and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our office.

Typical Uses and Disclosures of Health Information

We will keep your health information confidential, using it only for the following purposes.

Treatment: We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentially statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and controls disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, text messages, emails, postcards or letters.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $5.oo for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information; if you fell it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. You must submit a written request if there are any particular parts of this agreement that you wish to not agree to and/or if there is a particular person, business, or entity that you wish or practice not to share your information with. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Gamble Dental
7120 FM 1464 Suite B
Richmond, TX 77407

(832) 532-7242
(281) 271-8617
info@gambledental.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,____________________________, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign.**
- ☐ **Communication barriers prohibited obtaining the acknowledgement.**
- ☐ **An emergency situation prevented us from obtaining acknowledgement.**
- ☐ **Other (please specify)**

Office Financial Policy

- I understand that I am responsible for all fees related to my dental care and treatment
- I understand that full payment for all dental treatment is to be paid at the time the treatment is performed
- I understand that all account balances over 30 days old may incur a monthly interest charge at the maximum rate allowed.
- I understand that if a check, or other instrument, or any electronic authorization or debit sent or provided to Gamble Dental for payment is not honored at first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged the maximum allowable service charge of $30.
- I understand that if my account is not fully paid, my account may be turned over to a collection agency. In addition to paying my balance, I agree to pay all reasonable attorney's fees, collection and/or other court costs.

Broken And/Or Missed Appointments

- Gamble Dental reserves the right to charge a $35 fee for any appointment not kept by the patient. After two (2) broken or missed appointments, the dentist retains the right to discontinue elective treatment.

Patients with Dental Insurance

- I understand that my insurance policy is a contract between my Insurance Company and myself. Gamble Dental and its employees are not parties to my contract with my insurance.
- I understand that I am ultimately responsible for and all balances, even if my insurance company agrees to pay a balance and later does not pay.
- I understand that I may be given the option of only paying my estimated portion (that portion not covered by insurance) at the time of services. As a courtesy, the office will send my claim to the insurance company. If my insurance company fails to pay the balance, the balance is my responsibility and payment is due in full.
- I understand that if my first visit is an emergency visit, I will be responsible for payment of services in full at the time of the visit. As a courtesy, Gamble Dental will provide to me the necessary documents to file to my insurance company for reimbursement.

Patients with insurance, please initial the billing option of your choice:

____ I will pay my total balance at the time of service and will seek reimbursement directly from my insurance company.

____ I will pay only my estimated portion at time of service and have my insurance pay the office. If my insurance company fails to pay the balance, it remains my responsibility and I must pay all amounts due. If this is my first and it is an emergency visit, I understand that payment for all services is due at the time of treatment.

I have read, understood, and agree to the above Office Financial Policy.

____ ____/____/________

Signature of Patient/Guardian Date

PHOTOGRAPHIC RELEASE AND CONSENT

I hereby grant to the **Gamble Dental** and its representatives the irrevocable and unrestricted right to reproduce and display photographs of me in print, on the Gamble Dental website, or any other lawful purpose for advertising. I release Gamble Dental and its employees and legal representatives from any and all claims, actions and liability relating to its use of said photographs.

The following exclusions may apply: ____

Date: ____________________ Signature: ___________________________________

MINORS ONLY:

If signature above is by a person under the age of 18, parent or guardian should sign below:

I ______________________________ the parent or guardian of, ________________________ _________________ hereby consent to the foregoing.

Signature: ____

Date: ____________________________