



**Dr. Robert D. Perrott DMD, Limited**

7200 Bristlewood Drive, Youngstown, OH 44512

(330) 726-0090

www.perrottdmd.com/

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## NEW PATIENT FORM

### Basic Information

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

### Contact Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

### Address Information

### Emergency Contact

Full Name:		Street address:	
Phone number:		City:	
Relation:		State:	
		ZIP:	

### Work Information

Patient's signature:

Date:



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# PRIVACY POLICY CONSENT

## 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 the provider at the following address: 7200 Bristlewood Drive, Youngstown, OH 44512:
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 may 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 separately 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 the 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:

In order to stay within the HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information.	
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## FINANCIAL POLICY

### FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

### INSURANCE:

If you are currently enrolled in any dental insurance programs or change enrollment status at any point as an active patient of our practice, you MUST inform us about the policy before any appointments or services are rendered. This information is needed in order for any person and the office entity to remain Compliant with Insurance Fraud guidelines. Please remember your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware that we do not participate with ANY Medicaid policies. If you ever become insured with a Medicaid policy, the office will not be able to retain you as a patient as per office policy. You can call your Medicaid insurance carrier and get a list of participating providers in the area.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. Our office makes no guarantee or promises that your insurance will cover any or all of your treatment. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with dental claims, if your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and subject to finance charges and additional collection cost incurred from outside party to collect on your unpaid debt.

### PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the

dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. Please understand that we do NOT "Bill for Services".

#### PAYMENT OPTIONS

For patients without insurance, payment is due at the time of services rendered. We accept Visa, Discover, MasterCard, or Care Credit. For those that pay in cash or check will receive a 5% discount when paid same day of services rendered.

We are a participating provider with the Care Credit program, which is a credit card company that is specifically for medical use, but we are not affiliated with company. We do not have control over acceptance in the program, but our office staff can assist you in the application and payment process as much as we possibly can. The end result is a contractual agreement between you and Care Credit, not with the office. Care Credit does offer Deferred Interest over \$200 for a certain period of time and Reduced Interest with long periods of time for payment options. To see more details, visit [CareCredit.com](http://CareCredit.com) for more details.

MINOR PATIENTS that are seen for any type of appointment, it is the office policy that whomever brings the child in for their appointment will be responsible for any payment for services rendered that day.

UNPAID BALANCE over 60 day, you will receive a letter stating that you have 15 days to pay your account balance in full. Please be aware that if payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account. Payment in full will be required on past due balances before you will be seen again by the office.

#### DELINQUENCY/RETURNED CHECKS

Returned checks will be subject to additional fees and loss of check writing privileges in this office.

#### MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged \$50 cancellation fee. Please help us maintain the highest quality of care by keeping scheduled appointments. No future appointments can be scheduled without the payment of this fee. If three no-show or same day cancellations occur in a 12 month period, we reserve the right to terminate the doctor patient relationship. This policy is in effect for all appointments at our office

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature:

Date:



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## 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. Dr. Robert D. Perrott DMD, Limited 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. Dr. Robert D. Perrott DMD, Limited will use reasonable means to protect the security and confidentiality of email information sent and received. However, Dr. Robert D. Perrott DMD, Limited 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 Dr. Robert D. Perrott DMD, Limited and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Dr. Robert D. Perrott DMD, Limited.

Patient's signature:

Date:



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**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. Dr. Robert D. Perrott DMD, Limited, 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. Dr. Robert D. Perrott DMD, Limited will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Dr. Robert D. Perrott DMD, Limited 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 Dr. Robert D. Perrott DMD, Limited and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Dr. Robert D. Perrott DMD, Limited.

Patient's signature:

Date:

**PERMISSION TO LEAVE INFORMATION ON YOUR VOICEMAIL OR ANSWERING MACHINE**

**PURPOSE:** This form is used to obtain your consent to communicate with you by leaving a message on your voicemail or answering machine regarding your Protected Health Information. Dr. Robert D. Perrott DMD, Limited? if we are unable to reach you. However, **Dr. Robert D. Perrott DMD, Limited?** cannot guarantee the security and confidentiality of voicemail or answering machine 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 voicemail and answering machine communications between **Dr. Robert D. Perrott DMD, Limited ?** and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by **Dr. Robert D. Perrott DMD, Limited?**.

Permission to Leave Information on Your Voicemail or Answering Machine	
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