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DENTAL HEALTH

Hello! Dr. Rachel and I (Dr. Chu) would like to welcome you to the ARC Dental family! We thank you for entrusting us with your smile and dental health. Our belief here at ARC Dental is to provide our patients with high quality dentistry and exceptional service through open and honest communication and to treat you as family! We are committed to delivering to our patients five promises:

1. To treat you as you would like to be treated
2. To respect your time
3. To be minimally invasive and conservative with our treatments
4. To not just treat your dental needs but to also share our dental knowledge with you
5. To empower you to care for your teeth so they will last a lifetime

Our team looks forward to meeting and working with you! Please review the following information and if you have any questions please do not hesitate to call us.

The First Appointment:

On the first appointment a comprehensive exam will be conducted. It's a detailed evaluation of not just your teeth but also the soft tissues, bone, muscles and joints that are intra-oral and extra-oral. This detailed exam involves combining digital imaging and live evaluation of these structures.

The digital portion of our exam involves digital radiographs and digital photos. We understand that with taking of x-ray images there is always the concern of radiation. With the use a digital sensor we can provide high quality digital images at a fraction of the radiation from traditional x-ray films. And we strive to take the minimal number of images necessary to properly evaluate and diagnose any possible problems.

During the doctor evaluation part of the exam the muscles and skin around your face, head and neck will be checked for cancer and possible abnormalities. Your TMJ will also be evaluated for any signs of problems. Inside the mouth we check not only for cavities (caries) but also evaluate the health of your gums (gingiva), the underlying bone that supports your teeth, muscles and other soft tissues and conduct an intraoral cancer screening.

These findings will be used to determine your dental situation and help us to work with you in arriving at a treatment plan that best suits your dental needs and wants. After we have a treatment plan, the estimated costs will also be reviewed with you. If you have any questions regarding your treatment or estimated financial responsibility, please do not hesitate to ask our financial and treatment coordinator. We believe that providing you with a great dental experience includes a clear understanding about the treatments and finances and questions are always welcome.

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Oral Hygiene Appointment

After the comprehensive exam you will be scheduled a cleaning or hygiene appointment. Depending on the condition of your teeth and gums you may only need a regular cleaning or in the case of periodontitis you may need additional below the gum-line cleaning appointments. All cleanings will be done by one of our professionals. The hygiene appointment also includes a review of the latest home care techniques and tools to empower you to best care for your smile at home.

Financial Arrangements

Payment is expected at time of service. Our financial coordinator will help you with using our Credit Card processing service or other financial arrangements when extensive dental care is necessary. We will be sensitive to your financial circumstances within the framework of sound business practices. We want to be concerned with your dentistry, not financial responsibilities. Additionally, certain types of appointments may require a deposit, and this will be discussed prior to scheduling.

Dental Insurance:

We participate with many dental insurance plans and as a courtesy we will submit your claims for you. Your insurance policy is a contract between you and your insurance carrier so, we

expect you to be interactive with your insurance plan and be responsible for understanding your insurance benefits. In this regard we would like to offer the following tips:

1. We do our best to calculate your estimated patient financial responsibility through utilizing your insurances "automated" system.

2. You estimated patient financial responsibility is expected at the time of service. You are responsible for any amount not covered by your plan.

In the event your insurance carrier does not cover a service we provided or if there is a balance after your insurance has made their payment you are responsible for the remaining account balance.

Missed Appointments & Cancellations

Your appointment time has been specifically reserved for you. In order to avoid a last-minute cancellation or missed appointment fee we must receive 48 hours advance notice to reschedule. In the event this notice is not received your account will reflect a missed appointment fee based upon the length and type of your appointment. We urge our patients to "opt-in" to our confirmation service via text messaging or email. In addition, we always give a courtesy phone call up to one week prior to your appointment.

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Recalls

Upon completion of your dental treatment we will place you in our continuing care program and pre-schedule for your Periodic Recall. These appointments are designed to prevent little problems from becoming big or expensive ones. Preventive dentistry is the best and least expensive dentistry but is easily overlooked or postponed. Don't Miss Your Check-Up!

Your Feedback

Your satisfaction and happiness with our services are of utmost importance to us. If there is something you really liked, something you think we should improve on, a team member who deserves praise, etc. Please let us know, your feedback is greatly appreciated and respected!

Warmest Regards,

Alvin

Rachel

Alvin Chu DDS **Rachel Tambunan DDS**

Please take the time to complete all remaining documents to this letter.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notices of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to patient_____

Signature_____

Date_____

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	**Initials:**	**Reason:**

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FINANCIAL POLICY & AGREEMENT

Thank you for allowing us to be your dental care provider. We are committed to providing the highest quality of dental care to all of our patients. The prompt payment of your treatment fees allows us to continue providing the highest quality of care. In the pursuit of these goals, we have established the following financial policy:

ESTIMATES – We will give you a cost estimate before treatment is rendered. We will try to ensure that the cost estimate is complete and accurate; however, there are circumstances when it becomes impossible to know exactly what treatment needs to be performed. Sometimes the dental condition requires less treatment, in which case your treatment fees will be less than estimated. Other times, the dental condition requires more treatment than initially anticipated, in which case your treatment fees will be more than estimated. If more treatment is required than initially estimated, you will be informed of the treatment required and fees before the additional treatment is performed.

PAYMENT DUE – Full payment of the estimated fees are due at the time of service for the specific treatment that day. If your insurance covers only a percentage of the treatment, you must pay the estimated amount that is not covered on the day of service. Reimbursements will be allocated if need be after your claim is processed. If you are a cash patient, you must pay for the treatment in full. Patients that undergo treatment that requires lab fabrication (e.g. crowns, veneers, dentures, etc.) must be pay at least 50% of the total cost at the first appointment (prepping) and the rest at the delivery appointment. Payment of the balance must be made upon completion of the dental treatment. Any balance over 30 days will be subject to a finance charge of 5% per month.

PAYMENT PLANS – Payment plans are available. If a patient requests a payment plan, they have to pay 50% of the total cost of the entire treatment plan. The remaining will be subdivided into the number of months allowed for repayment. Any delinquent payments will incur any interest rate of 15% for each week past due.

BROKEN APPOINTMENTS – We reserve the right to charge a $75.00 broken appointment fee for appointments broken without a 48-hour notice.

AFTER-HOUR EMERGENCY CARE – We provide after-hours emergency care. There will be a fee charged.

INSURANCE – If we do not participate in your dental insurance plan, you still may receive benefits payable by your dental insurance company. You will be required to pay for treatment in full. We will file your insurance claim for you, assigning benefits directly to you. Your insurance company will reimburse you according to their own fee schedules and restrictions. We regularly monitor the usual and customary fees for our area and ensure that we are within this range. The insurance company's "usual and customary fees" are NOT based upon the current fees being charged in a particular area. If we are a participating provider for your dental insurance, we will file your insurance claim for you. We will estimate your insurance benefit and you will be required to pay the estimated balance at the time of treatment. Since the insurance benefit is an estimate only, you will be required to pay any amount still due after your insurance company pays on the claim. If there is a credit on your account after the insurance payment, this amount will be refunded to you or remain as a credit on your account for future treatment, as your choice. The

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OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS is made a part of this **Financial Policy & Agreement**.

COLLECTION OF PAST DUE ACCOUNTS – Accounts that are not paid according to this

Financial Policy & Agreement may be turned over to an independent collection agency. In the event that your account is turned over for collection, you will be responsible for all fees incurred in the collection of your account.

I, have read, understand, and agree to abide by this **Financial Policy & Agreement.**

Patient Signature: _____ Date: _____

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RELEASE FOR USE OF PHOTOS AND LIKENESS

BY

ARC Dental Health

I understand that **ARC Dental Health** (the "Practice") may take or receive photographs, video, audiotape and other image and sound-based media of its office, including its employees, patients, and other visitors. The Practice may wish to use such photographs for educational, promotional, advertising, and other purposes. This permission for release, without compensation or prior notice, would allow the Practice to use photographs in its printed publications, during presentations, and otherwise.

Therefore, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, or likeness by the Practice or its employees or agents for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, videotape, audiotape, film, photograph, television, radio, digital, internet, theater, or exhibition, at any time from this date forward until I revoke this consent in writing. I further waive any claims against the Practice, its employees, or agents based upon or related to its use or publication of my likeness, voice, participation, or picture. I freely give this authorization without expectation of compensation.

_____ _____

Signature Printed Name

_____

Address

Date _____

BY SIGNING OUR NEW PATIENT CHECKLIST, YOU ARE ACKNOWLEDGING THAT YOU HAVE READ AND UNDERSTAND THIS FORM

New Patient Appointment Check List

__ Bring One Form of Photo Identification – Type: _____ ID #: _____

__ Completion of Medical History

__ Proof of Insurance

__ I have read and understand the ARC Dental Health financial policy

__ I have read and agree to the ARC Dental Health HIPAA Authorization and Notice of Privacy Practices.

__ I give ARC Dental Health the permission to speak with the following individual regarding my financial, medical, treatment and emergency information.

_____

(Please write the individuals name and list the relationship)

We are excited to meet you and please do not hesitate to call us if you have any questions at all!

_____ _____

Patient Signature Date