"WHERE WE PROVIDE QUALITY CARE AND FRIENDLY SERVICE"

WELCOME

Thank you for scheduling your first appointment with Ivoir Smiles. My team and I would like to welcome you to our practice and make sure your first visit goes smoothly.

In this packet, you will find your registration forms. Please complete each form and provide it to our front office staff along with your Id card and insurance card.

It is our pledge to you that we will provide you with quality care and friendly service, using current technology. We take continuing education training very serious here. You can be rest assured that we can manage your oral health properly. We look forward to starting a great relationship with you and your loved ones.

Again, thank you for selecting our dental health care team. We're looking forward to seeing you, and we will do our best to serve you in a timely manner.

THE JOURNEY BEGINS TODAY!

Dr. Hendrick Tafo-Tabue and Staff

Getting to Know You

(Responsible Party for minor patients)

Full Name: _____ DOB: _____

Driver's License#_____ SS#: _____

Address: _____ Cell#: _____

City: _____ Zip_____ Home#: _____

Email: _____ Work#: _____

(Patient)

Full Name: _____ Date: _____

Preferred Name: _____ DOB: _____

Address: _____ Cell#: _____

City: _____ Zip_____ Home#: _____

Email: _____Work#: _____

Gender: M F Marital Status: Single Married Widowed

(Primary Insurance Information)

Employer: _____ Group#: _____

Subscriber Name: _____ DOB: _____

Dental Insurance Company: _____

Policy ID#: _____ SS#: _____

Insurance Telephone#: _____

Claims Address: _____

(Secondary Insurance Information)

Employer: _____ Group#: _____

Subscriber Name: _____ DOB: _____

Dental Insurance Company: _____

Policy ID#: _____ SS#:
_____Insurance Telephone#: _____

Claims Address: _____

Finance Agreement

Thank you for choosing us as your dental care provider. We are committed to providing you with the highest quality dental care, at a moderate price, using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and education tools so that you may fully participate in maintain optimum oral health. This financial agree is intended to facilitate our ability to provide excellent services to you.

Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express.

We offer financing through a company called Care Credit, which offers line of credit exclusively for your healthcare needs. Please ask our front office staff for more information for applying for credit.

Payment for services is due at the time services are rendered. (if materials, devices, or prostheses are to be fabricated by a laboratory a 50% deposit will be required at the time treatment begins. The remaining balance is due at the time of delivery. Other payment arrangements will need to be made prior to your appointment.

I understand that if a check, or other instrument, or any electronic authorization, or debit sent or provided to Ivoir Smiles, for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged. This charge is currently $25.00 and is subject to change without notice.

Insurance

We will process all your insurance claims and will do our best to help maximize your benefits. However, all charges you incur are your responsibility, regardless of your insurance coverage. If payment from your insurance company is not received. The balance on your account will become your responsibility. In this case, we will notify you, so you can make inquiries and arrangements as necessary.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Please understand that this co-payment is only an estimate, based on the information we have from your insurance company. Any charges not covered upon final reconciliation of insurance payments will be your responsibility.

OFFICE POLICIES

Dental Insurance co-payments are only best estimates. Your insurance company determines final payment of benefits. Various rules, restrictions, and deductibles may apply. Should you have an account balance after your insurance claims has paid, you will be sent a bill. **Payment of the bill is due upon receipt.**

Failure to pay a bill in a timely manner will result in the account being turned over to our collection authority. **The new balance will include all attorney fees and collection cost. Once an account is sent to collections you will not be able to return to the practice as a patient.**

There is a **$25.00 Return Check Fee** for any check returned for insufficient funds.

Failure to cancel an appointment at least 24 hours prior to appointment will result in a broken appointment fee per 30-minute appointment. 48 hours' notice is required for appointments 1 hour or more in length or for multiple family members.

Cancellations of appointments after a holiday should be done by noon on Friday or by noon on the last business day before the holiday.

There is a **$50.00** broken appointment fee.

We attempt to confirm all appointments as a courtesy to our patients.

We ask our patients to confirm their appointment by text, email, or telephone. Failure to confirm your appointment **could** result in your appointment being cancelled.

We appreciate after –hours telephone messages for routing purposes, but those messages do not give us sufficient time to fill an appointment on the next day. **An after-hours cancellation will be considered a broken appointment.**

Missing (3) Consecutive appointments without proper cancellation notice may result in dismissal from the practice.

If patient is a minor, you hereby give consent to treat the patient in our office with or without your presence. **You understand that the parent that accompanies a minor is responsible for payment.** For unaccompanied minors, non-emergency treatment will be denied unless payment arrangements have been discussed in advance.

Please sign and date this notice to indicate that you have read and understood it. It is very important that patients understand our office policies before commencing treatment.

DATE_____ PATIENT NAME_____

RESPONSIBLE PARTY
SIGNATURE_____PRINT_____

Appointment Reservation Policy

To provide you with quality care and the personal attention that you deserve, we design our schedule with the time slot that are customized specifically for your needs. However, we understand that circumstances arise that may not allow you to make your reserved appointment. Therefore, we have a 24-hour cancellation policy.

If an appointment must be cancelled, please call us at least 24 hours in advance to avoid a $50.00 cancellation/missed appointment fee.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

I understand this financial policy and that I am responsible to pay all fees associated with my treatment. I understand that estimates given to me are ONLY ESTIMATES and I am still responsible for any balances not covered by my insurance company.

I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.

If this account is assigned an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

I have received and signed a copy of the notice of practices for IVOIR Smiles of Midlothian.

_____	_____
Patient Name (Please Print)	Responsible Party
_____	_____
Signature	Date

General Consent for Treatment

All dental and anesthetic procedures have associated risks. These maybe, but are not limited to:

- Drug Reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.
- Complications from dental anesthesia, including involvement of the nerves resulting in temporary or possible permanent numbness or tingling or tingling of the lip, chin tongue, or other areas as well as involvement of the vasculature, causing bruising pain and/or swelling.
- Localized bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating in additional treatment.
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist
- Irreversible pulpitis – A small percentage of teeth prepped for restorative care may develop irreversible inflammation of the pulp causing chronic sensitivity, requiring root canal therapy.

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

_____	_____
Patient Name (Please Print)	Responsible Party
_____	_____
Signature	Date
_____	_____
Witness	Date

Thank you for choosing
Ivoir Smiles of Midlothian

Patient HIPPA 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 (HIPPA).*** 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 my payment from third party payers (e.g. my insurance company):
-The day-to-day healthcare operation of your practice.

I understand that I have the right to request restrictions on how my protected health information 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 used or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____
Print Patient Name Date

_____
Patient Signature/Responsible Party

Notice of HIPPA Consent to Release Health Information

Please list below the name of individuals whom you allow Ivoir Smiles to disclose the patient health information with.

_____
_____
_____
_____

Midlothian, VA 23113
804-897-8550

I AM WILLING TO HAVE MY PICTURE TAKEN AND GRANT PERMISSION TO USE MY PICTURE WITHOUT RESTRICTION FOR THE PURPOSES OF THIS OFFICE, BE IT PRINT PROJECTION, INTERNET WEBSITE, VIDEO OR ANY FUTURE MEDIA MARKET.

I EXPRESSLY RELEASE **IVOIR SMILES OF MIDLOTHIAN** MY PICTURE OR VOICE FROM ANY CLAIMS ARISING FROM SUCH USE OR DISTRIBUTION.

I AGREE TO BE FULLY RESPONSIBLE FOR MY OWN PARTICIPATION AND HOLD **IVOIR SMILES OF MIDLOTHIAN** OR REPRESENTATIVES HARMLESS FROM ANY LIABILITY, LOSS OF EXPENSE ARISING FROM THE USE OF MY PICTURE OR VOICE. I ALSO CONSENT TO THE USE OF MY NAME, MY VOICE AND/OR PICTURE, AND OTHER MATERIAL ABOUT ME FOR PROMOTIONAL, PUBLICITY, OR ORGANIZATIONAL PURPOSES.

PRINT NAME: _____ SIGN: _____

ADDRESS: _____

_____

_____

Phone: _____ Date: _____