Code of Conduct

FINANCIAL POLICY

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. 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 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.

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, estimate patient co-payments and deductibles are due at the time of service, unless other arrangements are made. Any unpaid balances over 90 days old will be subject to a monthly interest of 1.0% (APR 12%) and may be sent to a collection agency for recovery. If payment is delinquent, the patient will be responsible for payment of collection, attorneys' fees, and court costs associated with the recovery of the monies due on the account. A deposit may be required to reserve appointment times. This deposit is non-refundable but will be applied towards treatment.

CANCELLATION/APPOINTMENT POLICY

Our office does require appointment confirmations. To ensure that we can help as many patients as possible, we require a confirmation to keep your reserved appointment times. If your appointment is not confirmed at least 24 hours before your reserved appointment, your reservation may be given to another patient in need. To help aid you in this process, our office provides automated text and email confirmation reminders, as well as a call in advance from one of our team members to verify that the appointment time still works for you. We also ask for 48 hours' notice for any appointment changes and/or cancellations. Please help us maintain the highest quality of care by keeping scheduled appointments. Multiple missed appointments without sufficient notice will result in loss of ability to pre-appoint or require a non-refundable deposit to schedule.

COMMUNICATION CONSENT PURPOSE:

This form is used to obtain your consent to communicate with you by email, mobile text, and/or phone call(s) regarding your Protected Health Information. The Dental Spot offers patients the opportunity to communicate by email, mobile text messages, and phone calls. Transmitting patient information by email and electronic devices has several risks that patients should consider before granting consent to use email and electronic devices for these purposes. The Dental Spot will use reasonable means to protect the security and confidentiality of email and electronic device information sent and received. However, The Dental Spot cannot guarantee the security and confidentiality of email and electronic device 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 The Dental Spot and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by The Dental Spot.

Signature: _____

Printed Name (if different than Patient): _____

HIPAA Disclosure

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

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: 222 E Main St Suite 1C, Collegeville, PA 19426, USA

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 clients 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 individuals 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 individuals 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.

Signature: _____

Printed Name (if different than Patient): _____

Relationship (if different than Patient): _____

Health History

Medical Conditions

_____ ADD/ADHD _____ AIDS/HIV Infection _____ Alcohol/Drug Abuse _____ Anemia

_____Arthritis _____ Artificial (Prosthetic) Heart _____ Artificial Joint(s) _____ Asthma

_____ Autism/Mental Health Condition(s) _____ Autoimmune Disease _____ Bleeding Problems

_____ Cancer _____ Cold Sores _____ Diabetes Type I or II _____ Eating Disorder

_____ Epilepsy/Seizures _____ Frequent dry mouth/Sjogren _____ GERD/Acid Reflux

_____ Heart Disease/Heart Attack _____ Hepatitis/Jaundice _____ High or Low Blood Pressure

_____ Liver or kidney disease _____ Lung/Breathing Issues _____ Neurological Disorders

_____ Osteoporosis _____ Rheumatic Fever _____ Rheumatoid Arthritis _____ Severe headaches/Migraines

_____ Sinus Trouble _____ Sleep disorder/Snoring _____ Stomach Issues _____ Thyroid Problems

_____ Tuberculosis _____Ulcers

Do you have any medical conditions that were not previously specified? Yes | No

If yes, please specify: _____

Allergies

_____ Amoxicillin/Penicillin _____ Aspirin _____Codeine/Narcotics _____ Dental Anesthetics

_____ Erythromycin _____ Latex/Rubber _____ NSAID _____ Sulfa

Do you have any allergies that were not previously specified? Yes | No

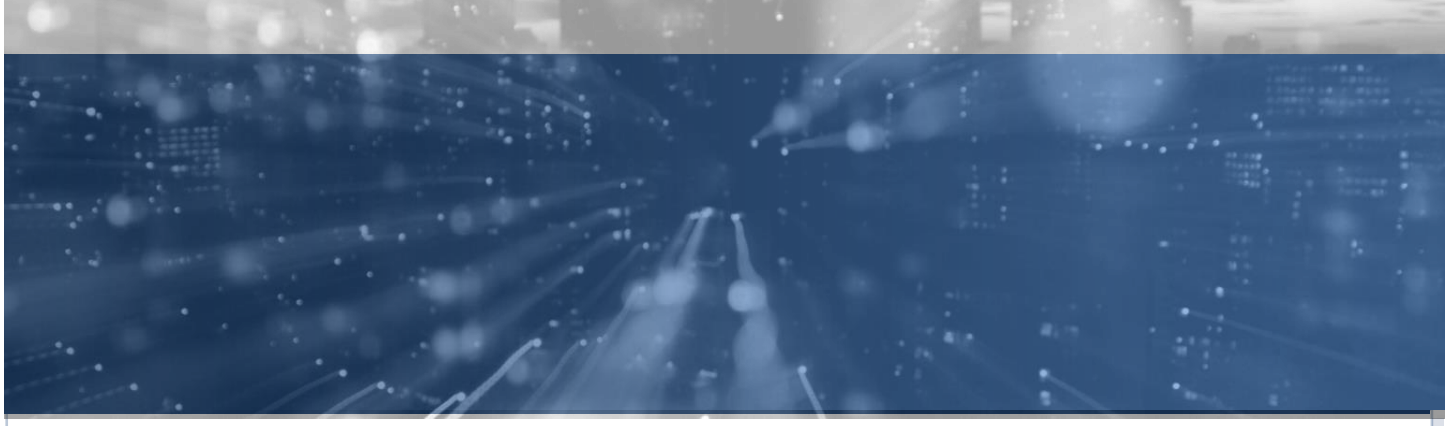
If yes, please specify: _____

Medications and Medical Devices

_____ Antibiotic Premedication _____ Birth Control _____ Blood Thinners

_____ Chemo/Radiation Treatment _____ Oral Bisphosphates _____Pacemaker _____ Wheelchair Bound

Please list all current medications: _____
_____



Medical History

Are you currently under the care of a physician? Yes | No

If yes, please provide the name and phone number of your physician: _____

Are you presently being treated for any injury or illness? Yes | No

Have you ever been hospitalized for an injury or illness? Yes | No

Are you currently breastfeeding, pregnant, or planning to become pregnant? Yes | No

Are you required to pre-med with antibiotics before dental treatment? Yes | No

How often do you consume alcohol?

- ☐ Never
- ☐ Very infrequently (1-2 times a month)
- ☐ Infrequently (Several times a month)
- ☐ Socially (1-2 times a week)
- ☐ Frequently (3-4 times a week)
- ☐ Very frequently (Almost daily)

Do you or have you ever used tobacco? Yes, currently | Yes, previously | No, never

Have you ever had an allergic reaction? Yes | No

Do you currently have or do you have history of head or neck injuries? Yes | No

Do you currently have, or do you have history of a medical condition or allergy that was not previously specified? Yes | No

Dental History

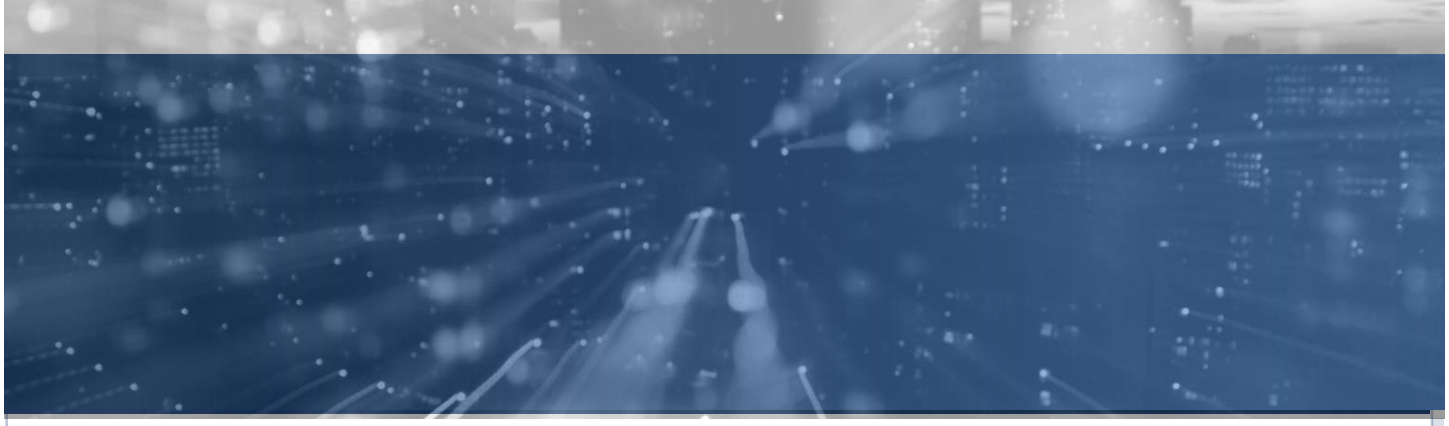
Who was your previous dentist? _____

Do you have any immediate concerns you would like us to address? Yes | No

If yes, please specify: _____

What do you value most in your dental visits? _____

Are you interested in improving your smile? Yes | No



Are your teeth sensitive to hot, cold, biting, and/or sweets? Yes | No

Do you clench your teeth during the day and/or nighttime? Yes | No

Do you bite your nails, chew gum, pens, or have any other oral habits? Yes | No

Do you often have a dry mouth or feel that the amount of saliva in your mouth is too little? Yes | No

Do your gums bleed when brushing or flossing? Yes | No

Have you ever been treated for or told you have gum disease? Yes | No

Have you ever had braces, clear aligners, or any other form of orthodontic treatment? Yes | No

Do you frequently get food caught between your teeth? Yes | No

Do you have any problems with your jaw joint? (TMD, popping or clicking, deviating from side to side while opening or closing) Yes | No

Signature: _____

Printed Name (if different than Patient): _____

Patient Registration

Personal Information

Full Name (First and Last): _____

Date of Birth: _____/_____/_____

Gender: Male Female Prefer Not to Specify Other

Social Security Number: _____-_____-_____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone Number: _____ Select One: Mobile Work Home

Phone Number: _____ Select One: Mobile Work Home

Email Address: _____

Emergency Contact

Full Name (First and Last): _____

Phone Number: _____ Select One: Mobile Work Home

Relationship to Patient: _____

Dental Insurance

Policy Holder's Name (First and Last): _____

Policy Holder's Date of Birth: _____/_____/_____

Insurance Company Name: _____

Member/Subscriber ID: _____

Insurance Company Phone Number: _____

Do you have a secondary dental insurance policy? Yes No

Signature: _____

Printed Name (If different than Patient): _____

Relationship (If different than Patient): _____