Sunshine Smiles Dental Care Appointment Policy

We value your time and always try to serve you in a timely manner. We ask that you extend the same courtesy in return. We understand that unplanned issues may come up and you may need to reschedule an appointment. Should you need to change a scheduled appointment, we respectfully ask that you contact us at with as much notice as possible or at least 24 hours in advance. Due to the large amount of time involved in treatment, other patients who may wish to take advantage of your appointment time require at least 24 hour notice to accommodate their schedule.

If you are over 15 minutes late for your scheduled appointment it may be necessary to change your appointment. Patients who are habitually late or miss appointments will be placed on the priority list. When an appointment becomes available, they will be called and given the opportunity to have the appointment. They will not be placed on the schedule in advance.

Thank you for being a valued patient and for your understanding and cooperation with this policy. This policy enables us to open otherwise unused appointments to better serve the needs of all patients. If you have any questions, please ask and we will do our best to answer them for you.

I understand the financial policy and appointment policy as stated. I understand that I am responsible for my dental cost regardless of any insurance coverage. I agree to notify the office within 24 hours to change a scheduled appointment.

Signature _____ Date_____

923 Bonifant Street
Silver Spring, MD 20902

PHONE 301-565-8889
EMAIL info@SunshineSmilesDentalCare.com
WEB SITE www.SunshineSmilesDentalCare.com

Sunshine Smiles Dental Care Financial Policy

We appreciate the opportunity to serve you. We have found that having a clear understanding of our financial policy may help to relieve some of the anxiety associated with dental visits. This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment.

Payment is due at time of service. We accept cash, check, Visa, Mastercard, Discover, and American Express. Debit cards displaying the Visa, Mastercard logo are also accepted. You may also use your flexible spending account through your employer, as long as they have provided you with a debit card. If we need to make payments over a period of time we have interest free options available upon approved credit with Care Credit. We are not a participator with Medicaid.

How would you like to pay for your services? Please check one:
_____Cash _____Check _____Credit/debit card _____Care Credit

If you have dental insurance, we will be happy to file your dental insurance claim as a courtesy to you. However, your estimated portion is just that, an ESTIMATE. If there is any remaining balance after we receive payment from your insurance company, that balance will be due within 30 days of notification.

If you have an issue with your payment, cannot pay in full at this time, please communicate with us to work out the issue and avoid going through the collection process. Failure to pay your account balance will result in your account being turned over to a collection agency. At such time, additional processing fees may be added and this action will adversely affect your credit rating. We would like to prevent using this measure and only plan to use it as a last resort.

As a courtesy, we offer a 5% discount for patients who pay in full at the time of service with check or cash for procedures more than $350.

If you have any questions, please ask and we will do our best to answer them for you.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected 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 Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 request restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____ Relationship to Patient_____

Signature _____ Date _____

Insurance Authorization Signature on File Form

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record. Please sign both authorizations.

AUTHORIZATION TO RELEASE INFORMATION: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

X _____ Date _____

Signed (patient, parent or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity.

X _____ Date _____

I _____, am aware that the insurance coverage fees presented to me by Sunshine Smiles Dental Care are only an estimate. All treatment not covered by insurance; I the guarantor will be responsible for the amount unpaid.

X_____ Date _____

Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Birthdate _____

Email _____ Soc. Security # _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Email Address: _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

X _____ _____

Signature of patient (or parent, if minor) **Patient number**

MEDICAL HISTORY

Physician_____Date of Last Visit_____

Address_____Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident?_____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

Signature: _____Date: _____