Rebol Family Dentistry
69 McDowell St, Asheville, NC 28801
(828) 253 5878
www.reboldental.com/?utm_source=GMBlisting&utm_medium=organic

NEW PATIENT FORM

Basic Information

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

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Complimentary Insurance Filing

Complimentary Insurance Filing

As a courtesy, we will file your dental insurance for you. We pledge to inform you of our fees for your care and will do everything in our power to help you recover benefits from your insurance carrier. Due to the limitations and exclusions of your dental insurance contract, your insurance may not cover 100% of the fee for your care and may exclude paying for some fees all together. We rely on your insurance company to provide accurate benefit information, some insurance policies pay on an allowance plan that they do not share with us. This information can be vague and misleading. Due to insurance laws we are unable to write off or discount any due balances once insurance pays their portion of your visit. You agree to be responsible for any fees that your insurance carrier does not pay for.

Our standard of care cannot be subject to the exceptions, exclusions, and limitations of various dental insurance policies. We will not compromise our ethical responsibility to diagnose treatment that is in your best interest. Every insurance plan has restrictions attached. We are committed to helping you with your dentistry, but our standards will not be limited by dental insurance plans.

By signing this you are stating that you understand that it is our ethical responsibility to recommend diagnostic and therapeutic treatment that is in your best interest and not to limit our recommendations based on the limitations and exclusions of your insurance company. You have been notified that your insurer may deny payment for the services rendered in our office and you agree to be personally and fully responsible for payment. Please dont hesitate to discuss further questions with our financial team.

Patient's signature: Date:

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NOTICE OF PRIVACY POLICIES

Rebol Family Dentistry Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY REBOL FAMILY DENTISTRY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.

Ask us to correct your health information you think is incorrect or incomplete. We may say no but will tell you why in writing within 60 days.

You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.

Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say no if it would affect your care.

If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.

Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.

Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.

Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.

File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, Taylor Whelan, taylor@reboldental.com, (828)253-5878, 69 McDowell St. Asheville, NC 28801.

File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting

www.hhs.gov/ocr/privacy/hipaa/complaints.

We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

Maintain the privacy and security of your protected health information.

Notify you promptly if a breach occurs that may compromise the privacy or security of your information.

Follow the duties and privacy practices described in this notice and give you a copy of it.

Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Most sharing of psychotherapy notes

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information We are allowed or required to share your information in other ways usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues: We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyones health and safety.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.

Respond to organ and tissue donation requests: We will share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when you die.

Address workers compensation, law enforcement, and other government requests:

For workers compensation claims

For law enforcement purposes or with a law enforcement official

With health oversight agencies for activities authorized by law

For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share your health information to respond to a court or administrative order, or in response to a subpoena.

Research: We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Privacy Officer Taylor Whelan

Email Address Taylor@reboldental.com

Phone Number (828)253-5878

Effective date: August 4th, 2008 Revision Date: August 29th, 2023

Patient's signature: Date:

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FINANCIAL POLICY

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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:

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.

a 10% DEPOSIT is due at the time of scheduling any appointment outside a routine visit in our office. This DEPOSIT goes towards your financial obligation on the day of your appointment and is non-refundable when you cancel your appointment within 48 hours of your reserved time.

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.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). 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.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be required to pay a $50.00 deposit to reschedule any visit in our office this will be in addition to the deposit owed for your visit. Please help us maintain the highest quality of care by keeping scheduled appointments.

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. Rebol Family Dentistry 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. Rebol Family Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Rebol Family Dentistry 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 Rebol Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Rebol Family Dentistry.

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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. Rebol Family Dentistry, 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. Rebol Family Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Rebol Family Dentistry 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 Rebol Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Rebol Family Dentistry.

Patient's signature: Date: