LANDMARK DENTAL

Dr Robin S. Kim | Dr Benjamin K. Lee | Dr Calvin K. Nguyen
Dr Jiwon Kim | Dr Christine M. Kim, Orthodontist

We are very pleased that you have chosen our office for your dental care. The staff is proud to have the opportunity to provide you with gentle, efficient and state or the art dental services. We hope to make your visit with us pleasant and comfortable as possible. Please take a moment to familiarize yourself with offices policies and procedures.

Office Guidelines

1. Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for our services at the end of each visit.
2. Our Front desk staff can tell you the approximate estimated fee for treatment prior to the next appointment. To make payments convenient for you, we take cash, personal checks, Visa, MasterCard & Care Credit.
3. Payment or co-payments and deductibles are required in full at the time of service. Any difference will be credited or billed after the insurance payment has been received.
4. **If you have any questions regarding your insurance coverage or co-payments, please let us know before any treatment starts. Otherwise, we will assume that you are familiar with your dental plan coverage and limitations**.
5. Please be advised that any co-payment amount is just estimated based on the information given by the insurance at the time a plan is verified. **The information given over the phone is not a guarantee of the payment by the insurance company, and actual payment may differ. Any insurance payment not received after 60 days becomes the responsibility of the patient for the full payment**.
6. **We require at least 24 hours advance notice on a business day for all appointment cancellations or rescheduling. A failure of the notice will allow the office to charge $25 per half an hour.** This time is reserved for you; proper notification of a change allows us to schedule someone else.
7. All filing of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by insurance company are the patient's responsibility. Any Assistance in this matter granted by the above Doctor and staff is given strictly as a courtesy and implies no responsibility on our part for filing, follow-through or confirmation.
8. If my account is placed in the hands of an attorney for collection, I agree to pay attorney's fees plus all court costs and interest in the amount of 1 ½ percent per month beginning 30 days after the payment becomes due or expenses have been incurred**. I understand and agree that the terms herein are reaffirmed each time services are received. I further agree to pay returned check charges of at least $25 per returned check. The above amounts are subject to change.**

I have read and understand the above policies, and agree to be held financially responsible.

_____ _____

Patient or Guardian's Signature Date

Patient Information

Patient Name:_____Date:_____
Last First MI (Preferred Name)

Gender(M/F):_____Marital Status:_____ Birth Date:_____ Social Security #:_____

Drivers License #_____E-Mail Address:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home_____Work_____Ext:_____Cell_____

In case of emergency who should be notified?_____Phone #_____

Referral Information

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

Name:_____Date:_____
Last First MI (Preferred Name)

Gender(M/F):_____Marital Status:_____ Birth Date:_____ Social Security #:_____

Drivers License #_____E-Mail Address:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home_____Work_____Ext:_____Cell_____

Employment Information

The following is for __the patient __the person responsible for payment

Employer Name:_____

Address:_____
Street City State Zip Code Phone #

Insurance Information

Primary

Name of Insured:_____
Last First MI

Insured's Birth Date:_____ ID #:_____Group #:_____

Insured's Address:_____

Insured's Employer Name:_____

Patient's relationship to insured: ___Self ___Spouse ___Child ___Other

Insurance Plan Name and Address:_____

_____

Secondary

Name of Insured:_____
Last First MI

Insured's Birth Date:_____ ID #:_____Group #:_____

Insured's Address:_____

Insured's Employer Name:_____

Patient's relationship to insured: ___Self ___Spouse ___Child ___Other

Insurance Plan Name and Address:_____

_____

Dental History

Reason for today's visit_____

Former Dentist_____

Date of last dental care_____ Date of last dental X-rays _____

How often do you floss?_____ How often do you brush?_____

Check if you have any problems with the following: __Bad Breath __ Bleeding gums __ Periodontal Disease
__ Clenching Mouth __ Grinding Teeth __ Sensitivity to cold, Hot, Sweets

Medical History

Physician's Name:_____ Date of Last Visit:_____

Have you had any serious illness or operations? ___YES ___NO If Yes, Describe_____

Have you had a blood transfusion? ___YES ___NO If Yes, give approximate dates_____

(Women) Are you Pregnant? ___YES ___NO Nursing? ___YES ___NO Taking birth control ___YES ___NO

Check if you have or have had any of the following:

__ AIDS	__ Chronic Sinus	__ Hemophilia	__ Psychiatric Care
__ Anemia	__ Circulatory Problems	__ Hepatitis	__ Radiation Treatment
__ Artificial Heart Valves	__ Cortisone Treatments	__ High Blood Pressure	__ Respiratory Disease
__ Artificial Joints	__ Diabetes	__ HIV Positive	__ Rheumatic Fever
__ Asthma	__ Epilepsy	__ Jaw Pain	__ Shortness of Breath
__ Blood Disease	__ Excessive Bleeding	__ Kidney Disease	__ Thyroid Problems
__ Cancer	__ Fainting	__ Liver Disease	__ Tobacco Habit
__ Cerebral Palsy	__ Heart Murmur	__ Mitral Valve Prolapse	__ Tuberculosis
__ Chemical Dependency	__ Heart Problems	__ Nervous Problems	__ Ulcer
__ Chemotherapy	Describe_____	__ Pacemaker	__Venereal Disease

MEDICATIONS **ALLERGIES**

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Financial Policy

IF YOU DO NOT HAVE DENTAL INSURANCE:
PAYMENT IS DUE AT THE TIME OF SERVICE
IF YOU HAVE DENTAL INSURANCE:
WE WILL ACCEPT BENEFITS FOR THE AMOUNT COVERED BY THE INSURANCE COMPANY. THE PART NOT COVERED BY THE INSURANCE COMPANY IS TO BE PAID AT THE END OF EACH APPOINTMENT. ALL DEDUCTIBLES ARE TO BE PAID AT THE END OF EACH APPOINTMENT.
ANY INSURANCE NOT PAID WITHIN 60 DAYS IS THE PATIENT'S RESPONSIBILITY.

EMERGENCY CARE:
ALL EMERGENCY CARE PATIENTS ARE EXPECTED TO PAY FOR THE CARE AT THE END OF THE VISIT.
CANCELLATION POLICY:
I UNDERSTAND THAT IF I CANCEL ANY DENTAL APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE ON A BUSINESS DAY, I WILL BE SUBJECT TO PAYING $25.00 PER HALF HOUR.

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____ Date:_____

*************SCANNED COPY SERVES AS ORIGINAL****************

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed on how you can get access to this information. Please review it carefully.

How your HEALTH INFORMATION may be used:

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other heath care personnel providing you with treatment.

To Obtain Payment

We may use and disclose your health information to obtain payment for services you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

To Conduct Health Care Operations

We may use and disclose you health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation certification, licensing or credentialing activities.

In Patient Reminders

We will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. They may include postcard, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We may disclose your health information to appropriate authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public Health And National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete and investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

Required By Law

We may use or disclose your health information when we are required to do so by law.

Persons Involved In Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event or your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only heath information that is directly relevant to the person's involvement in your healthcare, we will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Studies

We will not use your health information for marketing communications without your written authorization.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Your Authorization

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot disclose your health information for any reason except those described in this notice.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment

You have the right to request that we amend your health information, (Your request must be in writing, and it must explain why the information should be amended.) we may deny your request under certain circumstances.

Confidential Communications

You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Documentation of Health Information

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this account more than once in a 12 month period, we may charge you a reasonable, cost –based fee for responding to these additional requests.

Access

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health

information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for full explanation of our fee structure.)

Request a Paper Copy of this Notice

You have the right to obtain a copy of this **Notice of Privacy Practices** directly from our office at any time. Stop by or give us a call and we will mail it to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of revised Notice.

You have the right to express complaints to us or the Secretary of Heath and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient acknowledgement

Purpose of Consent

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by Contacting:

Debra Rogers
5130 Duke Street #4
Alexandria, VA 22304
(703) 370-6500
Fax: (703) 370-2800

Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Please print Name

Signature

Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name

Relationship to Patient

The following is a consent form for an Individual only, such as spouse or any family member.

Permission for Consent

I _____give_____
(Your Name) (Name or Names of Individuals)

Permission to discuss my dental account which includes treatment, balances, appointments, etc. with the office listed below and its employees: unless I notify you otherwise:

Landmark Dental
5130 Duke Street #4
Alexandria, VA 22304
(703) 370-6500

_____
Signature

_____
Print Name

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