LEGACY DENTAL
TIM BARLOW & CHAD PASTOOR
Est. 1994

Office Policies and Procedures

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care.

LATE AND MISSED APPOINTMENT POLICY

We put our faith in you to keep your appointment and arrive on time. When we set up an appointment; a specific amount of time is reserved especially for you. Many offices double or even triple book appointments to prevent from being financially damaged as a result of a missed appointment. However, double booking an appointment does not allow us to give the care and attention needed to provide excellent quality dentistry and for this reason we choose to not do it.

If for any reason you must cancel or change your appointment, it is important that you give our office **at least a 24 hour notice** to offer that appointment time to someone else. We do understand that true emergencies happen.

- **1st missed appointment**: If an appointment is missed or canceled within the 24 hour window, a letter will be sent to your home reminding you of our policy and the effect of your missed appointment.
- **2nd missed appointment**: After your second missed appointment, another letter will be sent to your home notifying you of a $60 missed appointment charge being added to your account. In order for you to schedule a future appointment with our practice this charge must be paid.
- **For all Restorative appointments**: A deposit will be required to schedule treatment. The deposit will be 50% of the cost of that appointments treatment or $100 whichever is greater. Upon arrival, this fee is credited toward the cost of the patient's treatment. If the patient does not show up to the appointment the deposit is non-refundable. If you choose to not pay the deposit you have the option of being placed on a short notice list and will be notified of last minute scheduling opportunities.
- **For all Hygiene/preventative appointments** after the 2nd missed appointment, the patient will be placed on a short notice list and will be notified when there is a cancellation or opening in the schedule. No hygiene appointments can be scheduled ahead of time until the patient's account is placed back in good standing. The decision to place the patient's account back in good standing lies at the sole discretion of the office manager.
- **3rd missed appointment:** After your third missed appointment; you may be dismissed from our practice.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases out ability to accomplish this. If you are more than 15 minutes late; your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

FINANCIAL AGREEMENT

Please understand that payment of your bill is considered as a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance forms prior to treatment.

For non-insured patients:

Payment for services are due at the time of your office visit unless prior arrangements have been made with our administrative staff. Payment options include: cash, check, MasterCard, Visa, Discover, and American Express.

Checks that are returned to our office from your financial institution are subject to a $40 returned check fee. This fee covers the processing fees that are charged to our office.

For insured patients:

As a courtesy to our patients, we will file all claims to their insurance company. Your insurance benefits are a contract between you and your insurance carrier. The amount of coverage you receive will depend on the plan purchased by you or your employer; not the fees of the practice. We will be happy to file your insurance as a service to you; however, we ask that you please furnish the correct insurance information. Unless other arrangements are made prior to service, I agree to pay all deductibles, co-pays, *and the patient "estimated" portion* in full at the time of service.

Patients with Blue Cross Blue Shield and Delta Dental will be required to pay for services at the time of your office visit unless otherwise advised due to these companies reimbursing the subscriber directly.

Minor Patients:

The adult Parents/Guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policyholder is.

_____I agree that Parents/Guardians are responsible for all fees services rendered for treatment of a minor/child.

Delinquent accounts

At 90 days past due, I agree to the extent permitted by the law, that if my account balance is referred to an agency or attorney(s) for collection purposes, to pay reasonable fees, expenses, or costs relating to the collection proceeding, including court cost. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable.

I have read this form and had an opportunity to ask questions. I agree to the terms of this agreement. No modifications apply to this document.

_____ _____

Patient or Parent/Guardian Signature Date

_____

Print Patient Name

PATIENT INFORMATION

Today's Date:_____

Patient Full Name:_____Date of Birth: _____

Address: _____City: _____State: _____Zip:_____

Cell Phone: _____ Home Phone:_____Work Phone:_____

Email Address: _____

Social Security Number: _____ Sex: M / F / O Marital status:_____

Employer:_____Occupation:_____

Emergency Contact Name: _____Emergency Contact Phone #: _____

Who may we thank for referring you? _____

MINOR CHILD PARENT/GUARDIAN INFORMATION

Mother Name:_____Mother Birthdate:_____

Father Name:_____Father Birthdate:_____

Who is responsible for this account?_____Relationship: _____

Name of legal guardian: _____

COMMUNICATION

My most preferred method of communication is (may pick more than one):

[ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Text Message [ ] Email

INSURANCE INFORMATION

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone Number: _____Group Number:_____

Subscriber ID or Member ID number: _____Policy Holder Employer:_____

Policy Holder Name: _____

Date of Birth of Policy Holder: _____Relationship to Policy Holder: _____

MEDICAL HISTORY

Physician's Name: _____Physician's Phone #:_____

Date of last physical: _____ Are you under the care of a physician? Y / N For what conditions?

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Y / N
If so, what: _____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication(s) at this time? Y / N If so what?_____

Do you suspect that you are pregnant? Y / N If yes, how many weeks? _____ Are you nursing? Y / N

Have you ever taken any of the group of drugs collectively referred to as "fen-Phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Y / N

Have you ever used bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Y / N

Have you ever had any of the following? :

Condition:	YES	NO	Condition:	YES	NO
Allergy to Anesthetics			Frequent Headaches		
Acid Reflux or gerd			Heart Problems: _____		
Anemia			Hepatitis A, B or C:_____		
Arthritis			High or Low Blood Pressure:_____		
Artificial Heart Valves or Joints			HIV/AIDS		
Anxiety and/or Depression			Kidney Disease		
Autoimmune Disease			Liver Disease and or Jaundice		
Back Problems			Recent Weight Loss, Gain or		
Bariatric Surgery			Respiratory Disease		
Blood Disease:_____			Rheumatic Fever		
Cancer: _____			Seizures		
Chemical Dependency			Stroke		
Circulatory Problems			Swollen Neck Glands		
Diabetes			Thyroid Disease		
Epilepsy			Ulcer		
Frequent Headaches			Venereal Disease/STD		

Are you currently following any special diet(s)? Y / N
If yes please explain:_____

Is there any additional information we should know about your medical history?_____

_____

DENTAL QUESTIONAIRE

What is the reason for your dental appointment today? _____

Are you experiencing any dental pain/discomfort? YES / NO

If yes, where is the pain/discomfort located?_____

When was your last dental exam and cleaning (MM/YY)? _____

Do you have dental anxiety or fear? _____

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

How often do you have your teeth cleaned? _____ How often do you change your toothbrush?_____

Are you please with the appearance of your teeth? YES / NO
If no, please explain:_____

Do you like your smile? YES / NO
If no, please explain: _____

Have you been pleased with your previous dental care? YES / NO

Have you ever had a bad experience in a dental office? If so, please explain: _____
_____

How can we help to improve your teeth and smile? _____

Please ✓ ALL that apply:

	✓		✓
Bad Breath		Pain around ear	
Biting cheeks or lips		Pain on brushing teeth	
Bleeding Gums		Periodontal Treatment	
Burning sensation on tongue		Prominent gag reflex	
Chew on one side of mouth		Pyorrhea or trench mouth	
Chewing		Sensitivity to hot or cold	
Chewing on foreign objects		Sensitivity when biting	
Clicking, popping or pain with jaw		Shifting position of teeth	
Dry Mouth		Snoring	
Fingernail biting		Sores, blisters, growths on lips or mouth	
Food Collections between teeth		Stained teeth	
Grinding or clenching teeth		Swallowing	
Gums swollen or Tender		Talking	
Jaw pain or fatigue		Thumb sucking	
Loose or broken fillings		Tobacco use	
Mouth breathing		Tongue thrusting	
Opening or closing jaw		Wisdom Teeth	
Orthodontic Treatment			

Dental Records Release

Date:_____

TO: _____

Address:_____

City_____State _____ Zip_____

Name of Patient_____Date of Birth:_____

I authorize the release of dental records including any current x-rays to:

Dr. Timothy S Barlow DDS

515 Keisler Dr. Ste 204 Cary NC 27518

Telephone: 919-859-5459

Fax: 919-859-9818

Email: staff@legacydentalnc.com

Signature of Patient or Parent/Guardian_____

Relationship to Patient_____

AUTHORIZATION TO RELEASE AND DISCUSS DENTAL INFORMATION
Timothy S. Barlow & Chad Pastoor, DDS, PA

Patient: Name _____ Birthdate: _____

The HIPAA privacy law requires that we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members and friends you want us to be able to speak with. **SPOUSES and PARENTS of those over 18 years of age are NOT automatically included; their names must be explicitly stated below.** You may opt out by checking "Do Not Release information" below.

AUTHORIZATION TO RELEASE INFORMATION AND SPEAK WITH FAMILY/FRIENDS (INCLUDING SPOUSE)

I give the following named person(s) authorization to take messages or speak with the office of Dr. Timothy S. Barlow, DDS, PA on my behalf regarding appointments, treatment, insurance and financial information.

- o Name of Authorized person(s):_____

  Relationship: _____ Phone number: _____

- o Name of Authorized person(s):_____

  Relationship: _____ Phone number: _____

- o If patient is a minor and will be accompanied by someone other than parent/legal guardian, please list authorized person below:

  Name:_____ Relationship_____

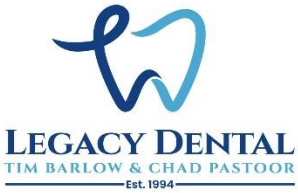
  Name:_____ Relationship_____

☐ **Do Not Release Information To Anyone**

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

X_____

Signature of Patient or Parent/Guardian Relationship to patient



ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of **Timothy S. Barlow, DDS, PA** Notice of Privacy Practices, which has an effective date of 04/14/2003, and which describes how my health information may be used and disclosed. I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices. My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____

Signature of Patient or Patient's Representative

_____

Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient