**AUGUSTA REGIONAL DENTAL CLINIC**

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ /_____ /_____ Gender: _____ Ethnicity: _____County/City of Residence: _____

Primary Phone #: _____Secondary Phone #: _____

Mailing Address: _____

Emergency Contact Name & Phone Number: _____

Do you have any dental insurance (including Medicaid): [] Yes [] No If yes, what type? _____

Employment: [] Employed [] Unemployed [] Student [] Retired [] Other: _____ Do you have Medicare?: [] Part A [] Part B [] None

**Assignment and Release:**

I certify that I, and/or my dependent(s), have insurance coverage with the above listed Insurance Company and assign directly to the Augusta Regional Dental Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Augusta Regional Dental Clinic may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

___**1. Patient Appointment Policies**

***Confirmation:*** We will attempt to confirm your appointment 4 business days prior. However, you must contact the clinic by 12pm the day prior to your appointment to confirm. Failure to do so will result in the appointment being cancelled. It is your responsibility to keep your contact information updated with the clinic. If your phone is disconnected, unable to receive messages, or if we are unable to leave a message, the appointment will be cancelled. Please arrive for your scheduled appointments on time. If you arrive more than 5 minutes late, we may reschedule your appointment and you will lose your pre-paid deposit. You must give at least 24 hours' notice if an appointment is being cancelled or rescheduled.

***Cancellations/No Shows:*** If you do not provide 24-hour notice to cancel or reschedule an appointment, you will lose your pre-paid deposit. Two No-Shows or Short Cancellations within a 12-month period means you will not receive another appointment at ARDC. *If you do not show up for your first scheduled visit, an appointment for a specialty visit or special event, you will not receive another appointment at ARDC.*

___**2. Treatment Plan Policy** If patient does not agree with the treatment plan, and their non-compliance jeopardizes the ARDC's ability to deliver an acceptable standard of care, or the patient insists upon a treatment that is not feasible at the clinic, patient will be required to seek care in private practice, or be dismissed from the clinic based on the individual situation. Please be advised our office policy is to use amalgam (silver) fillings on posterior (back) teeth and composite (tooth-colored) fillings on anterior (front) teeth.

___**3. Conduct Policy** The Dental Clinic is here to provide you and your children with the best care possible. Be respectful and cooperative to ARDC staff members as well as other ARDC patients; abusive behavior or profane language will not be tolerated. Any patient thought to be intoxicated or chemically impaired at any time, will be denied services or treatment and faces possible dismissal from the clinic. The ARDC reserves the right to determine whether a patient shall or shall not receive services at our Clinic. If you have a complaint or concern about the service you have received from the staff, please submit your concern to claims@augustaregionaldentalclinic.org.

*When adults are being treated, their children may not accompany them into the dental operatory. The dental department cannot provide child care while a parent is being treated.

___**4. Payment Policy** Advance payment is required before each uninsured dental visit and must be cash, money order or Visa/MasterCard/Discover/American Express. NO CHECKS ACCEPTED. Prepaid copays and fees for dental procedures must be used within 2 years of their payment date. If after 2 years, the prepaid amounts have not been used by the patient, they are considered forfeited and no refund will be granted by the ARDC.

___**5. Narcotic Prescription Monitoring System Policy** We participate in the Virginia Prescription Monitoring System.

___**6. Medicaid Patients: Non-Covered Services** We will submit dental insurance claims to Medicaid on the patient's behalf. In the event that the patient needs a service that is considered a "non-covered benefit" the patient will then be responsible for payment of these services.

___**7. HIPAA Privacy Practices, Consent for Treatment, Deemed Consent** I agree to the ARDC Notice of HIPAA Privacy Practices, Consent for Treatment and Deemed Consent and understand that a printed form is available should I choose to receive a copy. These consents are also posted in the lobby. By requesting care in the Dental Clinic, I am giving the dental provider permission to examine, diagnose and treat me (or my child). In the event of a blood borne pathogen exposure, I am deemed to have consented to testing and release of results to those exposed. I acknowledge that I will be thoroughly counseled before any testing as a result of exposure.

___**8. ARDC** does not discriminate based on race, color, national origin, religion, sex, gender identity, ( including gender expression) sexual orientation, disability, age, marital status, family/parental status, income derived from public assistance programs, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program of activity funded by USDA Rural Development.

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Patient or Parent/Guardian Signature Date