Welcome To Our Practice

We would like to thank you for choosing us as your dental care provider. We are pleased to meet any dental needs you or your family have. We will always do our best to give you the most up to date and professional care available. To avoid any confusion, we have listed below some of our policies and procedures.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the practice manager.

We accept the following forms of payment: Cash, Check, Visa, Discover & MasterCard.

Checks that are returned to our office from your financial institution are subject to a $50.00 returned check fee. This fee covers the processing fees that are charge to our office.

You are responsible to pay the cost of collecting any debt owed on your account. This includes all attorney's fees, late fees and interest to be charged at 1.5% per month.

Regarding Insurance

As a courtesy, we will file your dental insurance claim. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Most benefits will be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service.

Regarding Appointments

Broken appointments are very costly and inconvenient. Please inform us at least 1 business day in advance if you are unable to keep your appointment. Our normal business hours are Monday-Thursday from 8:00am-5:00pm. Appointments that are canceled without this notice are subject to a broken appointment fee of $50.00. Excessive broken appointments will lead to you and your family being dismissed from our practice.

If you are more than fifteen (15) minutes late for your appointment, you may be rescheduled for another day. This will be considered a broken appointment.

All patients under the age of eighteen (18) will not be seen or treated, in the absence of a parent or legal guardian, without a signed consent form.

I have read, understand and agree to the policies explained above.

____

Patient Name (please print)

____ ______________________

Signature of patient or Responsible Party **Date**

OFFICE GUIDELINES REGARDING DENTAL INSURANCE

Thank you for understanding that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can provide assistance with **estimating** your portion of the cost of treatment. However, we cannot guarantee what your insurance company will or will not cover in regards to each filed claim.

If we have received all of your insurance information on the day of your appointment, we will be happy to file the claim for you. Please become familiar with your insurance benefits, as on the date of service we will collect your estimated portion. If we are unable to verify insurance benefits due to insufficient or inaccurate information, you will be responsible for paying the full amount of your visit. By law your insurance company is required to pay claims within 30 days of receipt. We file most insurance electronically so your insurance company should receive each claim within several days of your treatment. You will be responsible for any balance remaining on your account after 30 days, whether insurance has paid or not. We will be glad to send you a refund once your insurance has paid us.

Please carefully read the following information that will help you understand some general guidelines about dental insurance benefits.

- No insurance pays 100% of ALL procedures – many patients assume their insurance pays 90%-100% of all dental fees. Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less.
- The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.
- Sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee (UCR) used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider "allowable".
- Our dental material of choice for "fillings" is a white filling, also known as composite resin. Some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam). The difference between the two fees will be your responsibility.
- Some dental insurers will not reimburse the provider (Dr. Sninski/Dr. Schmitt) directly for treatment but rather the subscriber. In this case, you are responsible for paying the full amount for treatment rendered on the day of service.

The following checklist is to assist you in preparing for your visit with Dr. Sninski or Dr. Schmitt. Your verification of this information will greatly help with filing your claim and speed up any refund you may be owed.

- ✓ Be sure you can currently receive benefits from your dental insurance policy and that there are no waiting periods.
- ✓ For each visit to our office please bring a current insurance card that includes the following: ID number, Group number, and the address and phone number for the insurance company. Some dental insurance plans do not issue a card; therefore we will need the social security number and date of birth for the person who carries the policy.
- ✓ The person who carries the insurance is the subscriber and we will need the subscriber's date of birth and employer information to expedite the processing of the claim.
- ✓ You may choose to contact your insurance company, in advance, to verify benefits, deductibles and benefit period maximums. This will enable you to become familiar with your particular plan and allow you to anticipate your level of benefits.

We know that filing insurance can be a time-consuming and somewhat confusing process. That is why we are happy to file your insurance for you. Thank you for reading our policy and familiarizing yourself with your insurance plan and the coverage you have.

Signature: ____ Date: ________________________________

Dental Insurance Information

Name of Primary Dental Insurance Company:
Insurance Company Phone Number:
Group Plan Name:
Group Number:
Policy Number:
Subscriber's Name:
Subscriber's Date of Birth:
Subscriber's Social Security Number:
Member ID Number:
Name of Secondary Dental Insurance Company:
Insurance Company Phone Number:
Group Plan Name:
Group Number:
Policy Number:
Subscriber's Name:
Subscriber's Date of Birth:
Subscriber's Social Security Number:
Member ID Number:

Parental Consent Form

Please read and initial beside each number:

1. I request and authorize Dr. Sninski, Dr. Schmitt, associate dentists and staff to perform the treatment and procedures for:

   Patient Name: ____

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the clinical faculty to diagnose and/or treat the patient's dental needs.

3. I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition/needs, the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

4. The usual and most frequently occurring risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain and/or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a tempromandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

5. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to, or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. If I am unavailable to be consulted all procedures will stop at that point and will not be continued until I am available for consultation. I am aware that the practice of dentistry is not an exact science and acknowledges that no guarantees have been made to me concerning the results of the dental treatment that the patient will receive.

6. I understand that at Sninski & Schmitt Family Dentistry dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. We will provide a clinical environment that is likely to help children to learn to cooperate during treatment. To accomplish this, the patient's behavior will be guided using praise, explanation, and demonstration of procedures and instruments, using variable voice tone and loudness.

7. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot safely be provided. During such disruptive behavior, it may be necessary for the assistant to hold the patients hands, stabilize the head, and/or control leg movements. If we still cannot provide treatment, we will reschedule the patient.

8. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.

9. I understand that I may revoke this consent, in writing at any time, and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

10. I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled and all inapplicable paragraphs, if any, were stricken prior to my signing below.

Signature of parent, legal guardian, or care taker: ______________________________________

Printed Name:____ Date: _______________________

Authorization for Release of Information

Name of Patient ___________________________________ Date of Birth _______________

Sninski & Schmitt Family Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other_________________________________
❑ Spouse	❑ Financial ❑ Medical as follows:_____________________ ____________________________________
❑ Parent (provide name) _________________________________	❑ Financial ❑ Medical as follows:_____________________ ____________________________________
❑ Other (provide name) _________________ ________________________________	❑ Financial ❑ Medical as follows _____________________ ____________________________________

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ Date:_______________

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

____

Sninski & Schmitt Family Dentistry
100 Ridgeview Drive Suite 103 Cary, NC 27511
919-467-2203

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: ____
____
____

I have received a copy of the Notice of Privacy Practices for the above named practice.

____ ________________________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other:____
____

Prepared By ____________________________________

Signature ____________________________________

Date ____________________________________

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____________
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ____ Phone ____________________

Child's History

Yes No

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .... 1. ❑ ❑
   If yes, please list: ____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ____________ 2. ❑ ❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: ____________ 3. ❑ ❑
4. How would you describe the child's eating habits? ____
5. Has the child ever had a serious illness? If yes, when: ____________ Please describe: ____________ 5. ❑ ❑
6. Has the child ever been hospitalized? .... 6. ❑ ❑
7. Does the child have a history of any other illnesses? If yes, please list: ____________ 7. ❑ ❑
8. Has the child ever received a general anesthetic? .... 8. ❑ ❑
9. Does the child have any inherited problems? .... 9. ❑ ❑
10. Does the child have any speech difficulties? .... 10. ❑ ❑
11. Has the child ever had a blood transfusion? .... 11. ❑ ❑
12. Is the child physically, mentally, or emotionally impaired? .... 12. ❑ ❑
13. Does the child experience excessive bleeding when cut? .... 13. ❑ ❑
14. Is the child currently being treated for any illnesses? .... 14. ❑ ❑
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ____________ 15. ❑ ❑
16. Has the child had any problem with dental treatment in the past? .... 16. ❑ ❑
17. Has the child ever had dental radiographs (x-rays) exposed? .... 17. ❑ ❑
18. Has the child ever suffered any injuries to the mouth, head or teeth? .... 18. ❑ ❑
19. Has the child had any problems with the eruption or shedding of teeth? .... 19. ❑ ❑
20. Has the child had any orthodontic treatment? .... 20. ❑ ❑
21. **What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water
22. **Does the child take fluoride supplements?** .... 22. ❑ ❑
23. **Is fluoride toothpaste used?** .... 23. ❑ ❑
24. How many times are the child's teeth brushed per day? __________ When are the teeth brushed? ____________ 24. ❑ ❑
25. Does the child suck his/her thumb, fingers or pacifier? .... 25. ❑ ❑
26. At what age did the child stop bottle feeding? Age ___________ Breast feeding? Age ___________
27. Does child participate in active recreational activities? .... 27. ❑ ❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ____________________________________ Date ____________________

For completion by dentist
Comments ____
____
____
____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by____________________
Date ____

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Form S707

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