SEATTLE PEDIATRIC DENTISTS

JON L. WAY, DDS, MS, PLLC
ELIZABETH VELAN, DMD, MSD

Dear Parent,

My staff and I wish to welcome you to our dental office. Our goal is to provide your child with the best oral health care in a warm and caring environment.

At the time of your visit, we will have a chance to discuss your needs and expectations. To help us prepare for your child's visit, we will need some information from you. Please complete the enclosed personal and medical history form and return it in the envelope provided. ***(WE ASK THAT THE MEDICAL HISTORY QUESTIONNAIRE BE RETURNED BEFORE YOUR CHILD'S VISIT. WE NEED TO KNOW OF ANY HEALTH CONCERNS AND/OR CONSIDERATIONS BEFORE THEIR VISIT SO WE CAN BE BEST PREPARED FOR THEIR TREATMENT.)*** Please list any other information that you think will be important in treating your child. We respectfully request that a parent be present at this appointment and subsequent visits to our office. This allows us to explain your child's needs, the treatment we are proposing, as well as, strategies to prevent future dental problems.

If you have dental insurance we will be happy to help you with the claim filing procedure. We ask that you bring your dental insurance card so that we may take a copy for our records. If your insurance company does not supply a card, please contact the insurance company and bring the complete information (i.e. subscriber's name, employer, social security number/identification number, group number and insurance company's claims address and phone number) with you at the time of your visit.
For those patients who do not have dental insurance, we ask that you pay for your services the day of your visit. We offer a 5% discount for payment by check. We also accept Visa, Master Card, American Express and Discover.

At your child's first visit we will do a complete oral examination, teach you and your child how best to care for his or her teeth, and discuss our recommendations with you. We will explain our procedures to your child in age-appropriate language. For most children this is an enjoyable visit that does not require a great deal of preparation beforehand.

Sincerely,

Jon L. Way, DDS, MS, PLLC

4500 SAND POINT WAY NE, SUITE 208 • SEATTLE, WA • 98105 Phone: 206.525.4777 • Fax: 206.525.8677

Seattle Pediatric Dentists

Jon L. Way, DDS, MS, PLLC **Elizabeth Velan, DMD, MSD**

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EMAIL: FRONTDESK@SEATTLEPEDIATRICDENTISTS.COM

Please help us prepare for your child's visit by completing this questionnaire as completely as possible.

Child Full Name_____ Nickname _____ Sex___ Age___ Birthdate_____

Child's Full Residential Address_____

Child lives with: Both parents Father Mother Step-Father Step-Mother Grandparents Guardian Other _____
Child's School or Preschool_____ Grade _____
Has any family member been a patient in our office? Yes___ No___ If yes, their name _____
If parent's cannot be reached, name of friend or relative to notify in case of emergency:
Name _____ Relationship_____ Phone # _____

THIS SECTION MUST BE COMPLETED IN FULL

Name_____
CIRCLE Father/Mother/Step-parent/Grandparent/Guardian

Street Address

City State Zip code

Home Phone Cell Phone

Email address

Social Security Number Date of Birth

Name of Employer Occupation

Work Phone Number

Name_____
CIRCLE Father/Mother/Step-parent/Grandparent/Guardian

Street Address

City State Zip code

Home Phone Cell Phone

Email address

Social Security Number Date of Birth

Name of Employer Occupation

Work Phone Number

Name of financially responsible party_____ Relationship to patient_____
Phone number if different from above_____

THE OBLIGATION FOR PAYMENT IS THE DIRECT RESPONSIBILITY OF THE PATIENT'S PARENT OR GUARDIAN, REGARDLESS OF INSURANCE. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL FEES FOR SERVICES. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.
Signature _____ Date _____

If you would like us to bill your dental insurance, please complete the following and provide a copy of your insurance card.
IF YOU HAVE DUAL INSURANCE, PLEASE PROVIDE FULL INFORMATION. WE ARE BOUND BY VERY SPECIFIC INSURANCE REGULATIONS AS TO HOW TO FILE A CLAIM FOR YOUR CHILD.

Primary Insurance Subscriber's Name_____ Subscriber's Employer_____
Name of Insurance Company _____ ID# or Social Security # _____
Group # _____ Mailing address_____
Phone # _____

Secondary Insurance Subscriber's Name_____ Subscriber's Employer_____
Name of Insurance Company _____ ID# or Social Security # _____
Group # _____ Mailing address_____

Phone # _____

Child's History

Is this your child's first visit to a dentist? _____ If NO, date of last exam _____ Was it a positive experience? _____
If No, please explain _____
How do you think your child will respond to this visit? _____
Name of former dentist _____
Does your child nurse/use a bottle/pacifier/suck their fingers or thumb? _____ During the day? _____ Nights only? _____
Does your child brush his/her teeth? _____ How many times per day? _____ Does he/she floss? _____ How often? _____
Does he/she use fluoridated toothpaste? _____
Has there ever been an injury to your child's tooth or teeth? _____ If yes, please explain what happened and the treatment _____
_____
What are the present dental needs as you see them? _____

Is Your Child..

Currently experiencing health problems _____ If yes, please explain _____
_____
Is he/she under the care of a physician for anything other than routine visits? _____
_____
Is he/she taking any medications? _____ Please list _____
_____
Is he/she sensitive or allergic to any medications, latex, foods? _____ Please list _____
_____
Is he/she currently taking a fluoride supplement? _____ If yes, what type? _____
Has your child ever been hospitalized or had an operation? _____ If yes, please explain _____

Immunization history:

Please circle all that are current

Polio Diphtheria Pertussis Tetanus Hepatitis A Hepatitis B MMR Chickenpox/Varicella Human Papillomavirus

Influenza Pneumonia Rotavirus Meningococcal

Has your child had a history of:

___ Asthma
___ Respiratory or lung disease
___ Allergies
___ Heart disease/defect/murmur
___ Rheumatic fever
___ Scarlet fever
___ Diabetes
___ Skin disease
___ Liver or kidney disease
___ Hepatitis
___ Jaundice
___ Tuberculosis
___ Blood disorder
___ Blood transfusions
___ Prolonged bleeding
___ HIV/AIDS
___ Fainting/dizziness
___ Epilepsy/seizures/convulsions
___ Cancer or other tumors
___ Problems with immune system
___ Cerebral or spastic condition
___ Hearing or speech difficulty
___ Blindness
___ Mental/emotional disturbances
___ ADHD, ADD

If yes to any of the above, please explain _____
_____
_____
Any other health issues? _____
_____
Child's Primary care physician _____ Phone number _____
Other physician _____ Specialty _____ Phone number _____
Other physician _____ Specialty _____ Phone number _____

Any comments, questions, or specific concerns? _____
_____

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I authorize Dr. Way and staff to use the anesthetics and premedications considered necessary or advisable for the comfort and well being of my child.

Parent/legal guardian signature _____ Date _____

Seattle Pediatric Dentists

Jon L. Way, DDS, MS, PLLC **Elizabeth Velan, DMD, MSD**

PLEASE SIGN AND RETURN THIS FORM WITH YOUR NEW PATIENT PAPERWORK

Financial Policy

We are pleased you have chosen us to provide your child's dental care. Please review this information regarding our financial policy. We hope you understand we have implemented these policies to avoid financial misunderstandings and difficulties that often arise when policies are not clear.

Insurance Billing

The responsibility for payment of our services is the direct obligation of the patient, regardless of insurance.
We will bill your dental insurance company for your child's services, provided you have given us complete and accurate information.
This includes: insured's name, date of birth, employer, often times the social security number (yes, many insurance companies still use the social security number as the ID#), member ID#, insurance company's name, address, phone number, and group number.
If you have dual insurance, we need the same information for both insured parents.
Be aware that dual insurance coverage does not always mean 100% coverage and full payment of your bill. Many companies have a dual benefit exclusion clause. You may have a balance due here.

Please do not ask us to call your employer to get your personal insurance information for you. By law, they are not permitted under the HIPPA Act to give an outside party (us) any of your personal information.

Though we may have some knowledge of your coverage, the number of policies and dental plans number in the thousands. We are unable to keep current with all of them, as they change frequently. It is your responsibility to advise us of any insurance changes. Changes normally occur annually, usually at the beginning of the new year.
You and your employer have purchased this policy, and the final decisions regarding their obligation for payment of services is between you and the insurance carrier.

Patients with some **REGENCE BLUE SHIELD**, **PREMERA BLUE CROSS**, and all **REGENCE FEDERAL** plans, please be mindful of the fact that these insurance companies send the benefit checks directly to you. They are generally made out to you and the doctor and should not be cashed by you without the doctor's signature. They are being paid to you with the expectation that you will forward the funds to our office. We respectfully ask that you endorse the insurance check, include any remaining balance due us, and forward it to our office.

Self-Pay Patients

We ask patients without dental insurance to pay for their services the day of their visit. We offer a 5% discount for payment by check at the day of the visit. We also accept MasterCard, Visa, American Express, and Discover. We DO NOT bill third parties. This includes divorced or separated parents. The financial agreements are between the parents of our patient and cannot involve our staff members.

Collection Policy

Accounts are considered past due after 30 days. We charge a $5.00 billing fee for all accounts due after 30 days. After 90 days, accounts may be turned over to a collection agency.

I have read this policy and understand that I am financially responsible for the cost of treatment and services, REGARDLESS of what my insurance carrier may or may not pay. Should I decide to dispute my insurance carrier's coverage, payment, or lack of payment, I will be responsible for late fees that may accumulate past 30 days while my account is pending dispute.

Parent Signature Patient Name Relationship to patient Date

Seattle Pediatric Dentists

Jon L. Way, DDS, MS, PLLC Elizabeth Velan, DMD, MSD
Diplomates, American Board of Pediatric Dentistry

STATEMENT OF PRIVACY PRACTICES

We are pleased you have chosen our office to provide your child's dental care. Dr. Way and Dr. Velan are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is the commitment of each employee to ensure that the patient's health information will not be compromised. We may, from time to time, need to amend our privacy policies but will always inform you of changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose information we collect from you only as allowed by the Health Insurance Portability and Accountability Act of 1996. This includes issues relating to treatment, payment and other dental care operations. However, this means personal protected health information cannot be otherwise given to anyone – even family members – without your written consent. You, of course may give written authorization for us to disclose information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of our patient's records is protected. Our privacy policy and practices apply to all current and former patients, so you can be confident that protected health information will not be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe the patient may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances.

We may use and/or disclose health information to communicate reminders about appointments including voicemail messages and postcards.

PATIENT RIGHTS

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed protected information for uses other than stated above. All such requests must be in writing. There may be a small fee for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We appreciate the trust you have in us to provide your children's dental care. Please let us know if you have any questions concerning your privacy rights and the protection of your personal information.

Seattle Pediatric Dentists

Jon L. Way, DDS, MS, PLLC Elizabeth Velan, DMD, MSD
Diplomates, American Board of Pediatric Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY POLICIES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE STATEMENT OF PRIVACY PRACTICES FOR THE OFFICES OF JON L. WAY, DDS, MS, PLLC. THE STATEMENT OF PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MIGHT OCCUR IN MY TREATMENT, PAYMENT FOR SERVICES, OR IN THE PERFORMANCE OF OFFICE HEALTH CARE OPERATIONS. THE STATEMENT OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND THE RESPONSIBILITIES AND DUTIES OF THIS OFFICE WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. THE STATEMENT OF PRIVACY PRACTICES IS ALSO POSTED IN THE FACILITY.

JON L. WAY, DDS, MS, PLLC RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE STATEMENT OF PRIVACY PRACTICES. IF PRIVACY PRACTICES CHANGE, I WILL BE OFFERED A COPY OF THE REVISED STATEMENT OF PRIVACY PRACTICES AT THE TIME OF MY FIRST VISIT AFTER THE REVISIONS BECOME EFFECTIVE. I MAY ALSO OBTAIN A REVISED STATEMENT OF PRIVACY PRACTICES BY REQUESTING THAT ONE BE MAILED TO ME.

ADDITIONAL DISCLOSURE AUTHORITY

IN ADDITION TO THE ALLOWABLE DISCLOSURES DESCRIBED IN THE STATEMENT OF PRIVACY PRACTICES, I HEREBY SPECIFICALLY AUTHORIZE DISCLOSURE OF MY PROTECTED HEALTH CARE INFORMATION TO THE PERSONS INDICATED BELOW.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES ___ NO ___
SPOUSE ONLY	YES ___ NO ___
OTHER (PLEASE SPECIFY)_____	YES ___ NO ___

_____

NAME OF PATIENT SIGNATURE OF PERSONAL REPRESENTATIVE

_____

DATE RELATIONSHIP TO PATIENT

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledge not obtained

Provided prior to treatment? _____YES _____NO

Date provided : _____

Reason for denial:

_____ Needed more time to review Statement of Privacy Practices

_____ Wanted to consult with another person, before signing

_____ Unable to sign

_____ Reason not given

_____ Other (please explain)

Seattle Pediatric Dentists

Jon L. Way, DDS, MS, PLLC **Elizabeth Velan, DMD, MSD**

Appointment and Cancellation

PLEASE SIGN AND RETURN WITH YOUR NEW PATIENT PAPERWORK

Dear Parent:

Your child's appointment time is reserved exclusively for you and your child. Promptness of this reserved time is essential to our office team, so that we may give equal time, attention, and respect for your time spent with us. Each appointment is designed to render the desired treatment and educational goals while at the same time, not overtiring your child. **We have put a great deal of thought into how to best accommodate all patients, as well as what times are best for treatment for the different ages of patients.**

We ask your cooperation in informing us **two business days in advance** if you must cancel your child's appointment. We realize children do become ill, family emergencies, and scheduling conflicts do occur, however, we ask that you make every effort to give us as much notice as possible, so that we may attempt to fill the vacated time. If one child cannot keep the appointment and he or she is scheduled with siblings, we ask that you make the effort to bring the other children that are scheduled. It is difficult to fill a last minute cancellation. It is nearly impossible to fill multiple cancellations from a family of children. We do charge a $75.00 fee per child per appointment for cancellations less than 2 full business days.

We request that a parent be present for all appointments. This allows us to explain your child's needs, the treatment we are proposing, and strategies to prevent future dental problems.

After school appointments are extremely popular in a pediatric office. Nearly every parent requests that time. While we do understand the reasons and the need for those times, please bear in mind that we cannot physically accommodate every child in our practice after school.

Please consider school days off, teacher in service days, early dismissal days, late start days, lunch times, study hall, and recess times.

Every month we send out notices to patients that are due for their semi annual check ups. We make additional after school appointment times available to accommodate patients after school needs. We limit these appointment times to semi annual check ups and emergencies. We schedule most restorative treatment in the morning hours.

Each time you come into our office, we will ask you to update a short health history form. Although it may seem repetitive to you, it is essential that we have accurate, very current information for your child's safety and well-being. Please be courteous and completely fill out the form.

As a dental practice that sees only children, we believe that we have much to offer you and your child. As specialists in Pediatric Dentistry, we have additional education and training in the unique needs of the child dental patient, and are accustomed to the many variables that working with young people entails. We hope you will be understanding of our policies and will allow us the privilege of treating your child.

I have read and understand the cancellation and appointment policies.

Parent Signature Patient Name Relationship to Patient Date