WELCOME TO NORTHERN MICHIGAN PEDIATRIC DENTISTRY!

Today's Date ________________ Child's Home Phone # __________________________ Social Security # ____________________

Child's Name ____ Child's Birth Date ______/______/_______ Age _______

Nickname ______________________ ◯Male ◯Female School ______________________________________ Grade _______

Child's Home Address ____
Street City State Zip

Sibling(s) Name(s) ____

Who may we thank for referring you? ____

RESPONSIBLE PARTY/PARTIES

MOTHER/PARENT 1 Birthdate _____/_____/_____ Home Phone # ________________ Cell Phone # ____________________

Name ____ Social Security # ______________________

Home Address ____
Street City State Zip

Driver's License or State ID# ____

Employer ____ Work Phone # __________________ Ext# __________

Email: ____

FATHER/PARENT 2 Birthdate _____/_____/_____ Home Phone # ________________ Cell Phone # ____________________

Name ____ Social Security # ______________________

Home Address ____
Street City State Zip

Driver's License or State ID# ____

Employer ____ Work Phone # __________________ Ext# __________

Email: ____

Who has guardianship/custody of the child? ______________________________ **Are the parent(s) married? YES NO**

IF parents are NOT married: Who does the child live with the MOST? ____________________________________

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Company Name ____ Subscriber's Name ______________________________

INS Identification # _________________________ INS Group/Plan # __________________ INS Phone # ______________________

Subscriber's Social Security # __________________ Birthdate _____/_____/_____ Relation to Patient __________________________

Secondary Insurance
Insurance Company Name ____ Subscriber's Name ______________________________

INS Identification # _________________________ INS Group/Plan # __________________ INS Phone # ______________________

Subscriber's Social Security # ____________________ Birthdate _____/_____/_____ Relation to Patient __________________________

FINANCIAL POLICY AND AUTHORIZATION

Payment or Co-Payment is to be paid in full at each appointment. We accept the following methods of payment: Cash, Money Order, Visa, Mastercard, Discover Card, CareCredit, & Personal Checks. Driver's License # or Sate ID # is required to accept personal checks in our office. I authorize the dental staff to perform the necessary dental services my child may need. I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company if being billed by the office to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the use of this signature on all insurance submission. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. I also understand that NMPD does not bill to Medicaid or Children's Special Health (Crippled Children's Fund).

Signature of Parent or Guardian ____ Date ______________________

DENTAL AND MEDICAL HISTORY

Patient Name____D.O.B.____________

Child's Physician______________________City_______________Phone #_______________

Date of Last Physical Exam_________________Results______________________________

Is the child under the care of a physician now? ☐Yes ☐ No

For____

Is the child receiving any medication? ☐Yes ☐No

List____

Last Dentist's Name___________________Phone #________________Date of Last Visit___________

Has your child had any dental x-rays taken within the last year? ☐ Yes ☐No

Has your child had any history or difficulty with any of the following? If yes, please check or circle.

☐ ADD	☐ Asthma/Breathing Issues	☐ Born Drug/Alcohol Addicted	☐ Spina Bifida
☐ ADHD	☐ Bladder Problems	☐ Epilepsy/Seizures	☐ Kidney/Liver Disease
☐ Apnea	☐ Cancer___________	☐ Fainting	☐ Clenching/Grinding
☐ Anemia	☐ Cerebral Palsy	☐ Hearing Impaired/Deaf	☐ Jaw Pain
☐ Autism	☐ Down Syndrome	☐ Heart Condition	☐ Tooth Injury/Trauma
☐ HIV/AIDS	☐ Sinus Problems	☐ Thyroid Disease	☐ Bleeding Gums/Pain

☐OTHER____

Ever been treated for Behavioral or Psychological problems?☐ Yes ☐ No

For____

Ever had Surgery? ☐ Yes ☐ No For____

Is there excessive bleeding when cut? ☐ Yes ☐ No

Any chance patient may be pregnant? ☐ Yes ☐ No

Does your child need Pre-Medication for a heart condition before dental treatment? ☐ Yes ☐ No

Latex Allergy? ☐ Yes ☐ No List other Allergies_________________________________

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who should we contact?

Name (Not parent)__________________________Relationship_____________Phone #_____________

Name (Not parent)__________________________Relationship_____________Phone #_____________

PATIENT CARE POLICY AND AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any change in my child's health status should occur. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Legal Guardian___________________________________Date_______________

PAYMENT OR CO-PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Northern Michigan Pediatric Dentistry, P.C.

1241 E 8th Street / Traverse City, MI 49686 / (231) 947-4566

IMPORTANT: Please understand, a parent or legal guardian must accompany the patient to the first appointments. Your child's first appointment will consist of a New Patient exam and consultation. Our office will schedule any treatment after this exam. Please bring this completed packet of paperwork, current dental insurance card, and driver's license. If you are more than 10 minutes late, or do not have the paperwork completed, your appointment may be cancelled.

Welcome

INITIAL EACH ↓

Appointment Policy

_______ A parent and or legal guardian must accompany the child to both the new patient and first treatment appointment visits. Doctor approval and written authorization from a parent or legal guardian is required if they are unable to bring to appointment other than listed previously.

_______ If the parent chooses to return to the referring dentist's office rather than continue with 6 month exams and cleanings here, any future referrals will require at least two appointments. The first appointment is for an examination followed by another appointment for any needed work.

_______ ALL FORMS MUST BE FILLED OUT FULLY AND COMPLETELY. Failure to fill out forms with required information that is requested could result in the child/patient not being seen.

_______ ***I UNDERSTAND I HAVE MEDICAID AND THIS OFFICE DOES NOT BILL TO WITH THE EXCEPTION OF HEALTHY KIDS DELTA DENTAL AND MICHILD PROGRAMS AND I STILL CHOOSE TO HAVE MY CHILD BE SEEN HERE AT SELF PAY. (MEDICAID/STATE PROGRAM PATIENTS ONLY)***

Cancellation Policy

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way the office can best serve the needs of ALL patients.

_______ We are committed to your child's dental health. Bearing these special needs in mind, the office requires a minimum of 24-hour notice if an appointment must be cancelled. 24-hour notification is considered business hours meaning any cancellations over the weekend from Thursday night thru the following Monday is not considered a 24-hour notice. If an appointment is missed without any contact or attempt during this allotted time, a letter will be sent to you. The first letter that is sent is a review of this policy. The second letter informs you that you are dismissed from the practice. We understand a child may become sick or unexpected events may result in you not making the appointment. In these cases, please contact the office as soon as possible.

We at Northern Michigan Pediatric Dentistry welcome you to our "family"! We look forward to taking care of your child's oral health needs.

______________________________ ______________
Parent or Guardian Signature Date

____
Parent or Guardian (Please Print)

____
Patient Name (Please Print)

Northern Michigan Pediatric Dentistry, P.C.

1241 E 8th Street / Traverse City, MI 49686 / (231) 947-4566

Written Financial Policy

Thank you for choosing Northern Michigan Pediatric Dentistry, P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible by offering several payment options.

Payment Options include:

- Cash, Check, Visa, MasterCard, or Discover Card (all with valid Driver's License)
- NO INTEREST[1] Payment Plans[2] for balances over $200 from **CARE CREDIT** **(must do credit application)**
  Must be present to sign with two forms of identification
  - Care Credit allows you to pay over time with NO INTEREST[1] **"IF"** paid in **promotional time**
  - Care Credit offers convenient, low monthly payment plans[2] also available
  - Care Credit has no annual fees or pre-payment penalties

Please note:

Northern Michigan Pediatric Dentistry, P.C. requires estimated co-payment **AT TIME OF SERVICE.** A $10.00 Delay of Payment Fee will apply to the account if any balance is not paid at the time of service. As a courtesy, we file a Pre-Determination for treatment to your dental insurance to get the estimated insurance portion for you. It becomes the patient's (parent/guardians) responsibility to cover procedures that are not covered by their insurance plan including ALL limitation policies. Not all services are covered by your insurance carrier and every insurance plan has its own unique "quirks" and exceptions. As a policy holder, it is ***YOUR*** responsibility to know your plan AND know and watch your plan limitations. WE ONLY USE COMPOSITE (WHITE) FILLINGS IN OUR OFFICE. You will incur an out of pocket expense if your insurance company reimburses at an amalgam (silver) filling rate. Contact your insurance carrier with any questions regarding your plan's benefit and limitations.

For patients with dental insurance (with the exception of Medicaid, Crippled Children's Fund, and CSHCS) we are happy to work with your carrier to maximize your benefit and as a courtesy we will directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and possibly getting collection of your benefits directly from your insurance carrier. If the account is not paid in full by 60 days, a letter and call(s) will be made before collection/court proceedings begins. A Billing Charge of $5.00 will apply to ALL statements that are sent. In the event of collection action, debtor agrees to pay all collection cost 28%, including reasonable attorney fees or additional costs associated in efforts of collecting or obtaining this debt. As an office policy, we do require a Social Security Number (SSN) for ALL policy holders AND guarantors (Responsible Party).

You agree, in order for us to service our account or to collect any amount you may owe, NMPD and associated 3rd parties of NMPD may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You DO specifically consent to receive telephone calls, short messages services, text messages, or other messages made or delivered to the telephone numbers that were provided. That you acknowledge that these call may be made or delivered using an automatic dialing system and/or an artificial or pre-recorded voice, made by the Center or its business associates for purposes of treatment, payment, and health care operations.

We are NOT responsible nor do we follow any parental agreements of percentage/or other party co-pays in separated families unless a copy of a court documented divorce decree is provided stating the office must take those percentages. It is a responsibility and an expectation that all balances will be paid at time of service by whomever brings them or by responsible party if additional monies are needed. Any balances will default to the guarantor on the account.

If you choose to discontinue care before treatment is complete, you will receive a refund if needed less the cost of care provided. All refunds, with the exception of Care Credit, are given by check from the Doctor. No appointments will be made if there is a balance on the account for patient or any members of their family.

We are unable to accept post dated checks. Northern Michigan Pediatric Dentistry, P.C. charges $35.00 for returned checks. You may no longer be able to use this form of payment for future visits.
**If you have any questions, please do not hesitate to ask and we will do our best to help.

____
Parent or Guardian Signature   Date

____
Parent/Guardian Name (Please Print)

____
Patient Name (Please Print)

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2] Subject to credit approval

Northern Michigan Pediatric Dentistry, PC
Matthew C Mandeville, DDS
James M Van Wingen, DDS, MS
Brandon D. Boike, DDS
1241 E 8th Street
Traverse City, MI 49686

I authorize the person(s) listed below, **in addition to the parent / legal guardians** to take my child to the above-named providers for treatment. I authorize the administration of measures as are deemed necessary for those appointments.

I hereby give permission to consent and authorize the names below to act on my behalf. I give them my permission to bring my child, to discuss, and to make dental decisions in all matters of the child. This includes but is not limited to making appointments, discussion of financial information, and authorizing of any form of treatment.

By listing the adults below, I authorize the staff of Northern Michigan Pediatric Dentistry to disclose any protected health information as needed to facilitate the dental care of my child. If you do not want anyone else to bring your child please write "none" and sign and date the bottom. This is active and current until I provide information in writing stating otherwise.

Name	Relationship to Child	Phone Number

Parent/Legal Guardian Signature________________________________ **Date**______________

Parent/Legal Guardian Printed Name________________ **Patient Name**__________________

Northern Michigan Pediatric Dentistry, P.C.

1241 E 8th Street / Traverse City MI, 49686 / (231) 947-4566

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain; including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

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

Michigan Dental Patient Consent Law: We are required by Michigan Law to obtain your written consent prior to making certain disclosures of your health information.

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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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.

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 of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health 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 interferences 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 Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

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 practically 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 will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $2.00 for each page, $20.00 per hour 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 a full explanation of our fee structure).

Disclosure Accounting: 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 5 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restricts 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {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.

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.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to use using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Matthew Mandeville
Phone: 231-947-4566
Fax: 231-947-9873

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:__________________ Patient Name: ____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other ____________________

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:____ Relationship:___________________________

Name: ____ Relationship: ___________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

______________________________ ______________________________

Please *print* name of Patient — Please *sign* Patient / Guardian of Patient

______________________________ ______________________________

Legal Representative / Guardian — Relationship of Legal Representative / Guardian

---

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)____

Signature of Privacy Officer ______________________________