Timothy P. Thomas, DDS, PC

You only get one first impression...How's your smile?

WELCOME TO OUR PRACTICE

On behalf of the entire team at Timothy P. Thomas, DDS, PC, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Health History and Registration and Dental Health forms that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.mylivoniasmiles.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Timothy P. Thomas, DDS

Timothy P. Thomas, DDS

37799 Professional Center Drive, Suite 101 • Livonia, MI 48154 • (734) 464-2664
Email: info@timothythomasdds.com • www.mylivoniasmiles.com

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Dear Patient,

We would like to extend a very warm welcome to our office and thank you for selecting us to care for your dental health.

It is our purpose to provide each patient with the highest quality of dental care in a gentle, efficient, and pleasant atmosphere. Our office is designed from the reception area to the care area with your family in mind. We want our patients to grow up with healthy teeth, attractive smiles, and a positive attitude toward dentistry. Our office staff and preventive philosophy will help achieve these goals for your family.

Enclosed you will find beneficial information as well as several forms to complete, including a health questionnaire, the Patient Acknowledgement and Consent (HIPPA Privacy Act), the Release of Dental Information, and the Antibiotic Premedication Protocol forms. Please complete all forms with the pertinent information and signatures. These forms are required for federal compliance and the American Dental Association recommendations for all patients.

Prior to your first visit to our office, we would like to have the names and phone numbers of previous dental providers (i.e. general practitioners, endodontists, oral surgeons, periodontists, and temporomandibular joint specialists) so that we may obtain any prior records, especially recent radiographs (within 2 years), so that we may better service your needs.

Generally, on your first visit, your medical and dental health will be assessed. You will be given a thorough professional oral examination and necessary x-rays will be taken for diagnosis, followed by a consultation of your dental needs. If you have an emergency dental problem requiring immediate attention, it will be taken care of initially. We will also take the time to discuss treatment plans, their significance, and costs, and financial arrangements will be made prior to servicing your dental needs.

An estimate for the comprehensive professional exam and radiographs is $165 to $240 without dental benefits.

Again, we welcome you to our practice. If we can help you in any way, please give us a call at your convenience. Our team is looking forward to meeting you.

Sincerely,

Timothy P. Thomas, DDS

Timothy P. Thomas, DDS
TPT/mk

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PATIENT REFERRAL PROGRAM

We want to help you and your friends receive the best possible dental care available. There are so many exciting new materials and techniques to restore teeth that most people don't know exist. We value good people, as we are sure you do, too. We still have space available for new patients in our office and we would like to offer anyone you know who would value quality dentistry a wonderful opportunity to receive a special courtesy free dental consultation appointment for new patient care.

For every patient that you refer to this office for dental care, we will credit your account with $50.00. Consider this a thank-you courtesy to be used towards any dental service that we provide! All that we ask is that you refer an individual outside of your immediate family who values quality dental care and personal attention. The greatest compliment you can pay us is by referring someone close to you.

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Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)

Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?……Yes ❑ No ❑

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you have missing teeth?_____ If yes, have you had them replaced?_____

If you have had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth?_____ How often do you floss?_____ What type of brush do you use? Manual ❑ Powered ❑

Do you avoid brushing any part of your mouth because of pain? Yes ❑ No ❑ If yes, what part? _____

Which foods cause you twinges of pain: hot ❑ cold ❑ sweet ❑ sour ❑ none ❑ Do you lose fillings or break fillings?……..Yes ❑ No ❑

Do you chew on only one side of your mouth?……Yes ❑ No ❑ If yes, explain: _____

Do your gums feel tender or swollen?……..Yes ❑ No ❑ Do you usually have many cavities?…….Yes ❑ No ❑

Do you clench or grind your jaws while sleeping or during the day?……Yes ❑ No ❑ Do your jaws ever feel tired?……..Yes ❑ No ❑

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

❑ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.

❑ Spreading payments out over time may help me to achieve the excellent results I desire.

❑ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.

❑ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.

❑ Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/ emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____

Would you like to have whiter teeth? ❑ Yes ❑ No

If you had a magic wand, what, if anything, would you change about your smile?_____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

PERSONAL DENTAL INTEREST YOU WANT TO DISCUSS

❑ Lighten all front teeth showing	❑ Rebuild fracture(s)	❑ Straighten rotation	❑ Eliminate dark or stained fillings
❑ Lighten single tooth	❑ Lengthen	❑ Straighten angulation	❑ Reduce gum showing in smile
❑ Close spaces between teeth	❑ Shorten	❑ Eliminate crowding	❑ Repair uneven edges

Please add anything you feel is important: _____

At Timothy P. Thomas, DDS, PC, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

YOUR DENTAL NEEDS

Your Name: _____ Date: _____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

• Are you having any areas of concern? _____

• What do you think is the present state of your oral health? _____

_____

• What do you already know about our office and what are your expectations? _____

_____

• How healthy do you want us to get your mouth? (please circle)

The best it can be Average Don't really care

• Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal When something is worsening When my tooth hurts or breaks

• What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best Average Just patch it

• We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

___ As a general dentist ___ As a cosmetic dentist ___ As a functional dentist

• How do you feel about the appearance of your face and smile? _____

_____

• What would it take for you to trust us to be your dentist? _____

_____

• Tell us about your good dental experiences. _____

• And the bad ones. _____

• Has fear ever been an issue for you in a dental office? _____

• What caused you to leave your last dental office? _____

• Has time ever been a factor in getting your dental work done? _____

• Has cost of dental treatment been a concern for you? _____

• What can we do to help you with this? _____

• Is there any additional information you would like us to know? _____

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COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

• Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other _____

• We provide various levels of sedation to ease your mind.
Would you benefit from a sedative?.....Yes ❑ No ❑

If yes, we provide: ❑ Nitrous Oxide (laughing gas)
❑ Mild sedative (oral medication) With mild sedative, you will need someone to drive you to and pick you up from the appointment.

• Our treatment rooms are equipped with cable TV and DVD players. Watching TV or a movie is an excellent way to pass the time during your visit. Please let us know what your favorite movie or TV show is, and at your next appointment we will make sure we have it for you to watch.

• We also have noise cancellation headphones for your use with personalized playlists.
Would you like to use headphones during your visits?..Yes ❑ No ❑

• Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

• Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?.....Yes ❑ No ❑

• Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?.....Yes ❑ No ❑

• Is there anything else we can do for you to make your visit comfortable?

_____

_____

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APPOINTMENT AGREEMENT

At Timothy P. Thomas, DDS, PC, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a $50 late cancellation charge.

We truly appreciate your understanding. Our goal at Timothy P. Thomas, DDS, PC is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Timothy P. Thomas, DDS, PC and agree to the "broken appointment" fee should I not give proper notification.

_____ _____

Signature of patient or responsible party Date

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FINANCIAL POLICIES

Here at Timothy P. Thomas, DDS, PC, our office policy regarding financing is as follows: As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or money order for services over $400.

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Timothy P. Thomas, DDS, PC and/or Timothy P. Thomas, DDS, PC's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient:_____

Signature of guarantor of payment/responsible party

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FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Prepayment in Full (For treatment over $400)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

B) Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your Visa, MasterCard, American Express, or Discover with an agreed payment amount each month. This allows you to make monthly payments without applying for additional credit.

C) Split Payment

1/3 of the total treatment is due at the preparation visit, the second 1/3 is due the day of cementation of the crowns/bridges/veneers, and the final 1/3 on the 15th of the following month.

D) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

E) CareCredit Plan

With fast approval over the phone from CareCredit, your payment can be much lower than those available through our office. CareCredit specializes exclusively in helping patients with larger dental cases to receive the treatment they want. CareCredit carries fixed rates and can extend terms out to 60 months. There is no prepayment penalty. We will assist you in contacting them from our office.

F) **Gradual Treatment Plan**

FOR THOSE PATIENTS ON A LIMITED BUDGET. By prioritizing treatment, those patients who do not have dental insurance or are on a tight budget can still complete their dental work by spreading appointments over several months or years. This plan has interest that applies each month.

G) Senior Discount

Seniors 65 years young receive a 10% senior discount on payment of patient responsibility.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks, or CareCredit Plan (see above).

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature:_____ Date:_____

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INSURANCE CLAIMS PROCESS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?
As a courtesy, we file private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. WE ESTIMATE YOUR PORTION BASED ON THE MOST UP-TO-DATE INFORMATION WE HAVE, BUT IT IS ONLY AN ESTIMATE ON A NON-PAR STATUS.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?
We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?
We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS
Our office does request payment in full for your estimated portion at the time of service. All accounts not paid in full after 60 days will be charged a finance charge at a rate of 2% per month (24% per annum). If you are in need of an extended option, please just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at your office, Timothy P. Thomas, DDS, PC.

Name:_____Date:_____

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SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Timothy P. Thomas, DDS, PC, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits…

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." Today, dental benefits are determined by the premium level in the group. Usually, the higher the premium, the higher the covered amount. Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum, or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

37799 Professional Center Drive, Suite 101 • Livonia, MI 48154 • (734) 464-2664
Email: info@timothythomasdds.com • www.mylivoniasmiles.com

Timothy P. Thomas, DDS, PC

You only get one first impression...How's your smile?

Authorization for Release of Dental Information

I, _____, authorize _____ and staff to release the following dental information to Timothy P. Thomas, DDS, and staff.

(Please initial appropriate line)

_____ Any and all of my dental records (as of the date of this release and 2 years prior if applicable)

_____ Any and all of my dental records **except** the following:
_____

This release authorizes the transfer of a duplicate set of records accrued within the previous two years. This release specifically allows the release of the following information (this information **will not** be released unless the appropriate line is initialed):

_____ Any record of treatment for Drug and/or Alcohol dependency or abuse

_____ Any record of Mental Health Treatment

_____ Any record of testing, care, treatment, reporting, or research pertaining to infection with HIV or related diseases

Transfer to: Timothy P. Thomas, DDS
37799 Professional Center Drive, Suite 101
Livonia, MI 48154
734-464-2664
info@timothythomasdds.com

Name of Patients to be transferred:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

S/_____ Date _____
Patient/Legal Guardian of Patient

S/_____
Witness

Timothy P. Thomas, DDS, PC

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Medical Recommendations during Maternity Care for Dental Treatment

Name _____

Authorization to transmit confidential information:

Signature _____

1. Doctor's Information

   Name _____

   Address _____

   Phone _____ Fax _____

2. Trimester 1 ____ 2 ____ 3 ____

3. Dental Treatment, Necessary or Anticipated: (Please Advise)

   _____

   "X-rays with lead apron for diagnosis"
   Restrictions? _____

   Antibiotic preferred _____

   Pain medication preferred _____

   Local anesthetic with/without epinephrine _____

   Procedures contraindicated during maternity _____

Signature _____ Date _____

Please fax return information to 734-464-4778

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Antibiotic Premedication Protocol
Rx American Heart Association

If you believe you, your child, or any family member has been diagnosed with:

- **Cardiac Transplant**
- **Replacement Cardiac Valves**
- **Bacterial Endocarditis history**
- **Shunts**
- **Congenital Heart disease/defects**

- **** <u>All</u> ** patients 1st 2 yrs after joint replacement and Rx is time extended with history of inflammatory conditions such as: Lupus, Rheumatoid Arthritis, Insulin-dependent (Type 1) Diabetes Mellitus, drug- or radiation-induced immunosuppressant, Malnutrition, Hemophilia history, or any Malignancy**

- ****All other concerns are on an elective basis****

We may recommend certain precautions be taken prior to dental treatment. Damage from bacteria can be harmful or fatal to someone with a heart or related problem. Pre-treatment antibiotics can help minimize the risks of this problem during any dental treatment and is advised by the American Health Association.

Please contact your physician or cardiologist for advice concerning pre-medication necessary to your specific medical condition and provide us with this information prior to any dental treatment, be it scheduled or an emergency. After the initial examination, our office can provide you with a prescription for pre-medication following the American Heart Association protocol.

Any deviation from the normal regimen is physician directed.
Rx Antibiotic prophylactic regimens taken 1 hour prior recommended for dental:

	Adults	**Children**
Amoxicillin	2 grams	50 mg/kg
Cephalexin	2 grams	50 mg/kg
Clindamycin	600 mg	20 mg/kg
Azithromycin	500 mg	15 mg/kg
Clarithromycin	500 mg	15 mg/kg

With the advice of the American Heart Association, this **medication <u>must</u> be taken <u>one</u>** (1) hour **prior** to your dental appointment. The time requirement is **<u>non-negotiable</u>** and **<u>mandatory</u>** for treatment.

Physician/Cardiologist_____ Phone #_____ Fax #_____

Physician/Cardiologist Signature_____ for

Patient Name _____**& Signature** _____
with Authorization to release and/or transmit confidential information

Rx Premedicate: Yes_____ **Elective**_____ **Antibiotic Regimen** _____

PLEASE DO NOT GUESS! We rely on the information you provide regarding your medical history. If there is **<u>any</u>** doubt
Antibiotic premedication is required until definitive need is diagnosed.
It is the responsibility of the patient to premedicate.

Yours in better dental health,

Timothy P. Thomas, DDS, and staff

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NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature:_____Date:_____

Please contact us for more information:
Timothy P. Thomas, DDS, PC
37799 Professional Center Drive, Suite 101
Livonia, MI 48154
(734) 464-2664
Email: info@timothythomasdds.com
www.mylivoniasmiles.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775

Timothy P. Thomas, DDS, PC

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (734) 464-2664 or by mailing us at 37799 Professional Center Drive, Suite 101, Livonia, MI 48154.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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