Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out the attached forms as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Today's Date:____________________

Name: __________________________ Soc. Sec. #_______-_____-_______

First Last Initial

If patient is a minor give Parent's/Guardian's name:____________________

Mailing Address:__________________________

Street/P.O. Box City State Zip

Physical Address:__________________________

Street Address City State Zip

Home Telephone Number:______________ Cell Phone Number:______________

Sex: Female______ Male______ Date of Birth:____________ Age:______

_____Single _____Married _____Widowed _____Separated _____Divorced

Employer:____________________ Occupation:______________

Employer's Address:____________________ Employer's Phone:______________

Notify in case of emergency:____________________ Relationship to patient:______________

Address:____________________ Phone:______________

Financial Information:

Name of person financially responsible for this patient:____________________

Relationship to the patient:______________ Date of Birth:______________

Telephone #:______________ Cell Phone #:______________

Soc. Sec.#:______________

Employer:______________ Employer Telephone:______________

Employer's Address:____________________

Insurance-We file with your primary insurance as a courtesy.

Primary Dental Insurance Company:____________________

Subscriber Name:______________ Employer This Insurance is Through______________

Subscriber ID:______________ Subscriber Date of Birth:______________

Relationship to Patient: Self Spouse Parent Other:______________

ALL PATIENTS/PARENTS/GUARDIANS- Please read and sign the statement below:

***I authorize release of any medical information necessary to process insurance claims. I permit a copy of this authorization be used in place of the original. I authorize any insurance benefits to be paid directly to Dr. Rothschild. I understand that only the primary insurance will be billed and that co-payments are due at time of service. I also understand that Dr. Rothschild will bill my insurance and if not paid within 45 days, **I WILL BE RESPONSIBLE** for the unpaid balance. In case of default, collection action will be taken; and guarantor agrees to pay all reasonable collection fees, including fees of an attorney and court costs. In the case of a divorce/separation only **one** person will be billed. I understand that Dr. Rothschild requires 48 business hours notification of any cancellation of an appointment in order to avoid the possibility of a charge to my account.

Signature:____________________ Date:______________

Patient Name:______________________________Patient Date of Birth:________________

Patient Medical History

Do you have any of the following?

	High Blood Pressure		Heart Disease		Chest Pains
	Heart Attack		Cardiac Pacemaker		Easily Winded
	Rheumatic Fever		Heart Murmur		Stroke
	Swollen Ankles		Angina		Hay Fever/Allergies
	Fainting/Seizures		Frequently Tired		Tuberculosis
	Asthma		Anemia		Radiation Therapy
	Low Blood Pressure		Emphysema		Glaucoma
	Epilepsy		Cancer		Recent Weight Loss
	Leukemia		Arthritis		Liver Disease
	Diabetes		Joint Replacement or Implant		Heart Trouble
	Kidney Diseases		Hepatitis/Jaundice		Respiratory Problems
	AIDS or HIV Infection		Sexually Transmitted Disease		Other:
	Thyroid Problem		Stomach Troubles/Ulcers		

Are you currently under a physician's care? Y___ N___ If yes, describe____

Physician's Name:___________________________________Office Phone:________________________________

Date of last exam:___________________________________

ALLERGIES (circle if applicable): Sulfa Drugs Penicillin or other Antibiotics Local Anesthetics Barbiturates

Sedatives Iodine Aspirin Latex Other Allergies:____

Are you currently taking any medications? Y___ N___ If yes, please list:____________________________________

Are you: pregnant or think you're pregnant? Y___ N___ Nursing? Y___ N___ Taking birth control pills? Y___ N___

Please check if you have any of the following:

________Gums bleed while brushing/flossing

________Sensitivity to sweet/sour foods/drinks

________Clench/grind teeth

________Prolonged bleeding following extractions

________Had orthodontic work

________Head/Neck/Jaw injuries

________Prolonged bleeding following extractions

________Blood Transfusion

________Sensitivity to hot/cold foods/drinks

________Sores/lumps in or near head, neck, or jaw injuries

________Bite lips/cheeks frequently

________Difficult extractions in the past

________Pain in any of your teeth

________Frequent Headaches

________Instruction on the care of your gums

________Instruction on correct method of brushing teeth

Have you ever experienced any of the following problems in your jaw (circle if applicable):

Clicking Pain(joint, ear, side of face) Difficulty opening/closing Difficulty chewing

Please Read and Sign Below:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

____ ___________________________

SIGNATURE OF PATIENT/PARENT/GUARDIAN **DATE**

DENTIST COMMENTS:

____

____

____

SIGNATURE OF DENTIST DATE

Kenneth Rothschild D.D. S.

FINANCIAL POLICIES
BROKEN APPOINTMENT INFORMATION
TRUTH IN LENDING STATEMENT

It is the policy of this office to collect payment for services as they are rendered. We will prepare insurance claims and accept assignment of your benefits for your primary insurance policy. Patients with insurance are expected to pay their co-pay. Any applicable deductibles or estimated portion not covered by insurance at the time services are rendered. All insurance claims are submitted daily. Any balance related to an insurance claim 45 days after the date of service is the patient's responsibility and is due at the time of service. This office is a preferred provider for Delta Dental insurance company.

Payment Options:

1. We accept cash, checks, and major credit cards or debit cards, including Visa MasterCard, and Discover. Because of the high discount rate, we do not accept American Express card
2. If special financial arrangements need to be made, those arrangements must be made with the office manager in advance of your first procedure.
3. Although we do accept the assignment of insurance benefits, under most circumstances, your insurance arrangement is a contract between you and your insurance company.
4. In the event of a divorce/separation only the financially responsible party will be billed. If this should change it is the patient's responsibility to inform Dr. Rothschild's office of such change.

Insurance Information:

1. Dental benefits are not meant to determine your health care but are to assist you in the payment of your treatment.
2. We are not responsible for determining what your particular benefits are.
3. We will do our best to see that you receive your full benefits, but your insurance policy is a contract between you and your insurance company.

Truth in Lending Statement:

1. As a condition of your treatment by this office, financial arrangements must be made in advance of treatment. We must have complete insurance information or a signed financial agreement if there is no insurance available. In order to provide our patients with the highest quality dental care we must insist on timely reimbursement for services rendered.
2. Patients who carry dental insurance understand that all services furnished are charged directly to the insurance company by means of insurance claims. Any payment and contracted discounts will be credited to the patient's account as soon as it is received. However, the patient is responsible for all fees not covered by insurance benefits or contracted discounts, and in the event of non payment of benefits within 45 days of date of service the patient assumes full responsibility of full payment.
3. A service charge of 1 ½% (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
4. Should an account be referred to a collection agency or to an attorney for collection, the patient is responsible for all collection fees, court costs, and attorney fees in addition to the balance of the account.

Broken Appointment Information:

1. The time of your appointment has been exclusively reserved for you. We require that you notify us of any cancellation at least 48 hours prior to your office appointment so that we may give your allocated time to another patient in need of our dental care.
2. The first incident of an office appointment that is missed without 48 hours notification will be documented and the broken appointment fee may be waived.
3. If a second office appointment is missed without 48 hours notification a $50.00 per 30 minutes scheduled appointment will be charged to your account.
4. If a third appointment is missed without 48 hours notification you will be asked to pre-pay your appointment at the rate of $50.00/30 minutes or be scheduled on a short notice basis.

*****SIGNATURE REQUIRED: I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AND APPOINTMENT POLICIES.**

______________________________ __________________

Patient/Parent/Guardian Signature **Date**

Dr. Kenneth Rothschild, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

Dr. Kenneth Rothschild, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

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. A copy of our Notice accompanies this Consent. 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:

Contact Person: ______________________________

Telephone: ______________________ Fax: ______________________

E-mail: ______________________________

Address: ______________________________

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 Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent 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 heath 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 to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________________

Dr. Kenneth Rothschild, D.D.S.

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 (MM/DD/YR), 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 to 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 healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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 inferences 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 practicably 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 $0.25 for each page, $25.00 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 6 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 restrictions 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 Web site 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 us 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.

Telephone: 703-777-3150 Fax: 703-777-2464

Address: 823 South King Street, Suite E, Leesburg, VA 20175

Informed Consent

This is my consent for Dr. Kenneth Rothschild and/ or any of his coworkers to perform the following treatment procedure(s) or surgery:

____ General Dentistry to include but not limited to: exams, cleanings, x-rays,

____ fillings, crowns, periodontal therapy, limited orthodontic services,

____ routine oral surgery extractions, fabrication of appliances or other services.

____ as previously explained to me, or other procedures deemed necessary or advisable to complete the planned procedure/ surgery.

____ I understand that the purpose of the treatment/ procedure/ or surgery is to treat and possibly correct my undesirable oral condition. The doctor has advised me that if this condition persists without treatment, my present condition might worsen in time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) diseases, dental caries, jaw fractures, and/ or premature loss of bone. I have been informed of possible alternative methods of treatment.

____ Dr. Kenneth Rothschild has explained to me that there are certain inherent and potential risks in my treatment procedure.

____ If any unforeseen condition should arise in the course of my treatment/ procedure/ surgery, calling for doctor's the judgement or for procedures in addition to or different from those now contemplated. I request and the doctor does whatever he may deem advisable.

____ No guarantee or assurance has been given to me that the proposed treatment will be curative and/ or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective treatment, or worsening of my present condition despite the care provided. However, it is my doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur without the recommended treatment.

I CERTIFY THAT I HAVE AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT.

______________________________________ ______________

Patient, Parent, or Guardian's Signature Date

PATIENT FINANCIAL AGREEMENT

Kenneth Rothschild DDS
823 South King St. Suite E
Leesburg, VA 20132
(703)777-3150

Patient Name: ____

Description of Treatment: ____________________________________

The TOTAL FEE for the proposed treatment is: $ _______________

_____ **OPTION 1 Courtesy for payment in full at the time of service with cash or check.**
A courtesy of 6% is offered for payment in full with cash/check at initial treatment appointment.
The 6% courtesy for treatment is $___________. The adjusted fee for the treatment is: $___________.

_____ **OPTION 2 Courtesy for payment in full at the time of service with credit card.**
A courtesy of 3% is offered for payment in full with a credit card at the initial treatment appointment.
The 3% courtesy for treatment is $___________. The adjusted fee for the treatment is: $___________.

_____ **OPTION 3 Insurance**

We have a pre-treatment estimate on file for this visit. Your insurance company has indicated that they
Will pay the following for the above-stated treatment: : $___________.
Based on the pre-treatment estimate, the amount due at this visit is: $___________.
After thirty (30) days from the treatment date, I authorize my credit card to bill billed to pay any
Remaining balance left on my account if my insurance company does not pay what they originally
estimated.

Credit Card Number ______ Expiration Date ______ Security Code ______

_____ **OPTION 4 Monthly Payment Plan**

For patient who prefer to make monthly payments, we offer short-and long term financing through an outside healthcare financing company. Please let us know if you would like information about this option.

I have been informed of the treatment fee(s) and I understand that I am responsible for the total treatment fee regardless of my dental insurance policy. I understand that any dental plan I have is strictly a contract between myself and my insurance carrier. I understand that Ken Rothschild does not have a relationship with any insurance carrier and therefore is unable to determine the exact amount paid by my insurance. I agree to pay in full any account balance remaining within 30 days if my insurance benefits are less than the estimated amount or denied for any reason. Ultimately, I, the Patient/Guarantor, am responsible for all treatment fees incurred in this office.

Patient/Guarantor Signature Date **Staff Member Signature Date**