AS YOU ARE AWARE, THE CENTERS FOR DISEASE CONTROL AND PREVENTION HAS ISSUED WARNINGS AND PRECAUTIONS TO HEALTH-CARE PROVIDERS WORLDWIDE REGARDING CORONAVIRUS.

WE ARE TAKING EVERY PRECAUTION NECESSARY TO LIMIT THE EXPOSURE OF ANY VIRUS WITHIN OUR OFFICE, AND WE ASK THAT YOU HELP US BY PARTICIPATING IN THESE PRECAUTIONS.

1. UPON YOUR ARRIVAL TO OUR OFFICE, WE KINDLY ASK THAT YOU USE HAND SANITIZER OR WASH HANDS.

2. PLEASE DISINFECT YOUR HANDS PRIOR TO USING ANY PENS TO FILL OUT ANY DOCUMENTS WE MAY NEED FROM YOU.

3. IF USING THE RESTROOM OR EXITING AND RE-ENTERING OUR OFFICE, WE ASK THAT YOU WASH YOUR HANDS OR USE THE HAND SANITIZER PROVIDED UPON RE-ENTRY.

4. PLEASE INFORM US IF YOU ARE CURRENTLY EXPERIENCING A FEVER, COUGH, OR DIFFICULTY BREATHING.

5. PLEASE NOTE THAT WE WILL BE LIMITING SOCIAL DISTANCE, INCLUDING HANDSHAKING, AS A MEANS OF DECREASING POSSIBLE TRANSMISSION OF CORONAVIRUS (COVID-19).

6. PLEASE INFORM US OF ANY RECENT TRAVEL OUTSIDE OF THE US TO AREAS CONSIDERED LEVEL 3 PRECAUTION BY THE CDC. THIS INCLUDES THE FOLLOWING COUNTRIES: ITALY, SOUTH KOREA, IRAN, CHINA OR ANY COUNTRIES AS DIRECTED BY THE CDC OR STATE DEPARTMENT (AS OF MARCH 5, 2020).

7. ALSO, PLEASE INFORM US IF YOU HAVE TRAVELED WITHIN THE US. WE THANK YOU FOR YOUR CONSIDERATION AND PARTICIPATION IN THESE OFFICE POLICIES.

DUE TO THE CORONA VIRUS PANDEMIC, WE ASK THAT PATIENTS WHO HAVE FLU LIKE SYMPTOMS TO POSTPONE ELECTIVE DENTAL PROCEDURES UNTIL THEY ARE WELL.

IN THE LAST 14 DAYS HAVE YOU HAD FLU LIKE SYMPTOMS SUCH AS:

YES NO DIFFICULTY BREATHING (SEVERE)

YES NO COUGH (DRY)

YES NO SORE THROAT

YES NO FEVER

YES NO HAVE YOU BEEN IN CLOSE CONTACT WITH OR HAVE RECENTLY TRAVELED TO ONE OF THE COUNTRIES WITH LARGE OUTBREAKS OF COVID-19? THIS INCLUDES THE FOLLOWING COUNTRIES: ITALY, SOUTH KOREA, IRAN, CHINA OR ANY COUNTRIES AS DIRECTED BY THE CDC OR STATE DEPARTMENT (AS OF MARCH 5, 2020).

YES NO HAVE YOU BEEN EXPOSED TO SOMEONE WHO WAS DIAGNOSED WITH COVID-19 OR WHO WAS QUARNTINED AS A PRECAUTION? IF YES, YOU MUST WAIT 14 DAYS TO SEE THE DENTIST.

THESE ARE PRECAUTIONS MANDATED BY THE CENTER FOR DISEASE CONTROL AND ENFORCED BY THE AMERICAN DENTAL ASSOCIATION FOR THE PROTECTION OF PATIENTS AND DENTAL PERSONEL.

THANK YOU FOR UNDERSTANDING.

SIGNATURE: _____ DATE: _____

PACIFIC FAMILY DENTISTRY

Patient Information:

Patient Name: _____ Pronoun_____

Age: _____ SS#_____ Employer: _____

Check Appropriate Box: ☐Minor ☐Single ☐ Married ☐Divorced ☐Widowed ☐ Separated

How did you hear about our office? _____

Responsible Party Information: (If ***not*** the patient please complete)

Parent or Spouse Name: (circle one) _____

Address: (if different from above) _____

Phone #: _____ Cell Phone #: _____ Is this person currently a patient? Y or N

Birth Date: _____SS#_____

Employer: _____ Work Phone: _____

Insurance Information: (If ***other than*** patient or responsible party please complete below)

Please Present office with your insurance card.

Insured's Name: _____ SS#: _____

Birth Date: _____ Ins ID#: _____ Ins Company: _____

Employer: _____

Do you have secondary coverage? Please present office with that insurance card as well.

Insured's Name: _____ SS#: _____

Birth Date: _____ Ins ID#: _____ Ins Company: _____

Employer: _____

Authorization and Release

Our dental office will gladly assist you in filing your insurance claim, but we are unable to accept responsibility for collecting your claim if there is a dispute. It is your responsibility to pay for the entire amount not covered by your dental benefit plan. By signing this form, you hereby assign all payments for services provided for yourself or dependents to Emergency Dental Care, USA.
All accounts 30 days and over are past due and will be subject to an interest rate of 18% per annum. All collections 90 days past due may be turned over for collection. In the event, you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees.

_____

Responsible Party's Signature **Date**

PACIFIC FAMILY DENTISTRY
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)

_____
(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)

PACIFIC FAMILY DENTISTRY

Office Financial Policy

Welcome Pacific Family Dentistry, the office of Sang Shin, D.D.S. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements. Please don't hesitate to talk to us about any questions or concerns you may have.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, AmEx, Discover, Care Credit, money orders or registered checks. Payment arrangements can be made for larger balances. We are here to help you afford your dental treatment. Let us know how we can help!

Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if we are unable to verify your insurance information before treatment.

Any deductible or estimated co-payment amount will be due at the time of treatment.

If payment for services already rendered has not been paid in full within 60 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

Appointments are reserved exclusively for you. We spend an extensive amount of time preparing for your visit, to make sure you have a seamless and pleasant experience. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If you find that you must change your appointment, please call us at least i24 hours in advance. A late cancellation or if you fail to keep your appointment, may result in a missed-appointment charge of seventy-five-dollars ($75). Any missed appointment 2 hours or more in length will incur a one hundred and fifty-dollar ($150) fee. This fee will not be covered by your insurance company.

Separated or divorced parents of minors, who are responsible for one half of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non-custodial parent on file.

Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

_____ _____ _____

Printed Name Signature Date