Dear Patient,

Welcome to the practice, we look forward to helping you with all of your dental needs! We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception; dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of copayment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

Sincerely, Alpine Dental

_____ _____

Signature Date

Dear Patient,

I would like to thank and welcome you to our office! I'll start by sharing with you what our guiding beliefs are for our patients. Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them, recognizing that not all patients have the same dental needs or desires. With that in mind, we would ask you to identify how you would like to be seen in our office by checking which of the 3 levels seem appropriate for you at this time. Please understand that it is not uncommon for patients to choose a different path after they have experienced our office, but this helps as a starting point.

- ☐ Level 1: Reactive Care, patients at this level are generally only interested in solving more urgent problems and not in a comprehensive exam or long term planning. In addition they typically want the treatment performed to be as inexpensive and efficiently as possible.

- ☐ Level 2: Proactive Care, patients who choose this level of care generally want a thorough examination and want to be involved in the prevention of present and future dental problems. Typically; however, they choose repair solutions that are not long term in nature.

- ☐ Level 3: Regenerative Care, patients at this level have a high value for their dental health and appearance. They desire a complete dental examination and have a desire to be informed of all findings and the potential consequences of each problem. Ultimately they want to be involved in creating a long term master plan for their dental health which includes choosing the longest lasting solutions to their problems.

We hope these different levels make sense to you, and as we stated before, it is not uncommon for patients to change levels after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care most appropriate for you.

Cancellation Policy for Dental Appointments

We understand that cancellations are sometimes unavoidable, but the scheduling time lost is extremely costly to our practice. Due to the high costs involved in having the appointment time available for you, effective January 1st, 2022 there is a charge of $50 per missed appointment. These fees are not covered by insurance, it is the sole responsibility of the patient, and it must be paid in full prior to the patient's next appointment. ___Initial

We utilize emails and text messaging to remind you of upcoming appointments. A reminder is sent two weeks prior to your appointment so that you may choose to reschedule if needed. An additional email and/or text message is sent 48 hours prior, allowing you to confirm the appointment by email or a return text message response. It is your responsibility to confirm the appointment as most hygiene appointments are made 6 months in advance. If you chose to opt-out of this communication, we are not responsible to remind you by phone. If your schedule is constantly changing and does not permit advance scheduling, you can request to be added to our list for same day/last minute openings.

- Cancellation or rescheduling of an appointment with more than 48 hour notice will result in no charge. You can cancel by calling 703-455-0409 or responding to the reminder text. ___initial
- A missed appointment is considered one that is cancelled/rescheduled less than 48 hour notice, or one where patient does not show up to an appointment. If your appointment falls after a weekend, it is your responsibility to contact us to cancel/reschedule by 4pm on the Friday before your appointment ___Initial
- If you are more than 15 minutes late to your appointment without providing an advance notice, it is considered a missed appointment, and may result in a cancellation fee – in the event we are able to reschedule for the same day, your fee may be waived. ___Initial
- After 3 failed appointments you risk being dismissed from our practice for an abundance of missed appointments. ___Initial

Patient Signature_____ Date_____

Financial Policy

Thank you for allowing Alpine Dental to provide you with the best care for your dental needs. We ask you for your understanding and appreciate your cooperation with our financial policy.

Payment options: Payment is due at the time of service unless alternative agreements in writing have been made in advance.

- Pay by cash, check, or credit card
- Open an account with the Care Credit card and received interest-free options

Regarding insurance: If you have insurance, and wish us to wait for payment, we will submit claims to your insurance carrier. Co-pays are due at the time of service. If your insurance carrier does not compensate the office for services rendered within 45 days the balance will then revert to the responsible party. The balance due (Unless prior arrangements have been made) must be paid in full within 30 days

Note: Please remember that the insurance quotes are only estimates. Your dental insurance is based upon contract between the subscriber's employer and insurance carrier. The benefits that are discussed with you at the time of your appointment are not guaranteed payments from the insurance carrier. You may be billed after the insurance payment is received for an additional payment.

Return checks: Personal checks that are returned due to "Insufficient funds" Are subject to a $50 service fee

Missed appointments: Please carefully schedule your appointments and help us treat our patients by keeping your scheduled appointment. A fee of $50 is charged for every appointment that is missed without a 48-hour notice.

X-ray release: There's a fee of $30 for a release of x-rays and or records.

I have read and understand the financial policy of Alpine Dental. I agreed to be responsible for payment in terms of all services rendered on my behalf of my dependents.

_____ _____

Patient Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____

Date: _____

Photo/Video Release

I, _____, grant Alpine Dental a license to reproduce and use any photographs, still or video images, or audio recordings of me, and any testimonial I issue regarding my health care services at Alpine Dental, for any of the following purposes:

- Alpine Dental website, social media, online and printed articles, mass advertising mailings, brochures, booklets, flyers, reports, event displays and other similar marketing materials and/or activities directed to prospective patients.

- Alpine Dental is authorized to use all or any portion of the Marketing Materials without royalty or recompense of any kind, in unlimited quantities and for an unlimited period of time.

- I release Alpine Dental and any of its associated or affiliate companies, their owners, directors, officers, agents, employees and appointed advertising agencies from all claims of any kind arising out of the use of the Marketing Materials as described in this Release.

- In the event I want Alpine Dental to cease using the Marketing Materials, I understand I must provide 60 day written notice to Alpine Dental to discontinue use of the Marketing Materials. Alpine Dental shall have the right to continue to use the Marketing Materials during the 60 day notice period and shall further have the right to exhaust its supply of products containing any portion of the Marketing Materials ordered or received prior to Alpine Dental's receipt of the written notice.

Signature: _____

Print Name: _____

Date: _____