CHILD'S REGISTRATION AND INFORMATION

Date _____

Child's Name _____ Nickname _____ Sex_____

Age _____ Date of Birth_____

Residence address:

_____

City State Zip

Parent 1 Name _____ SS#_____ Date of Birth

_____/_____/_____

Parent 2 Name_____ SS# _____ Date of Birth

_____/_____/_____

Parent 1's e-mail _____

Parent 2's email _____

Home phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Home phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Parent's marital status: Please circle one Married Single Divorced Widowed Separated

Whom may we thank for referring you? _____

Names and ages of other sibling's _____

Person to contact in case of emergency _____ Phone # ( ) _____

RESPONSIBLE PARTY

Name of person financially responsible for this account _____ Relationship _____

Address _____

☐ If same as above

Home phone ( ) _____

How do you intend to pay? Please circle one: Cash Check Credit card

As a courtesy to all of our patients, we will submit insurance claims on your behalf at the time of visit to our office; however upon the initial visit, full payment is required. For visits thereafter only 20% of the cost of service for all procedures is due at the time of treatment (depending on your insurance). Please be advised that if insurance payment is not received within 30 days you will be sent a statement in the mail in which you will be responsible for the remaining account balance.
I understand that failure to keep my balance current will result in the account being forwarded to a collection agency.
I am responsible for all collection charges and legal fees associated with my failure to pay my bill. Please see the front desk if you have any questions or concerns about this policy. This policy does not apply to orthodontic treatment, Please see our staff for our policies regarding this type of treatment.

_____

Signature of Parent of Guardian Date

CHILD'S INSURANCE INFORMATION

ALTHOUGH WE DO NOT PARTICIPATE IN ANY DENTAL INSURANCE PLAN (OUT OF NETWORK PROVIDER), WE WILL MAKE EVERY EFFORT TO MAKE YOUR VISITS AS SEAMLESS AS POSSIBLE. AS A COURTESY TO YOU, WE WILL SUBMIT YOUR DENTAL CLAIMS AFTER YOU HAVE PAID OUR OFFICE FOR SERVICES RENDERED.
IN ORDER TO SUBMIT YOUR CLAIM, PLEASE PROVIDE US WITH INFORMATION REGARDING YOUR PLAN.

Primary Dental Insurance

Insurance Company: _____ ID #: _____

Name of Policy Holder: _____ Date of Birth_____

Policy Holder SSN: _____ Insurance Phone #: _____

Group Name: _____Group #: _____

Insurance Phone #: _____ Claims Address: _____

_____

Secondary Dental Insurance

Insurance Company: _____ ID #: _____

Name of Policy Holder: _____ Date of Birth_____

Policy Holder SSN: _____ Insurance Phone #: _____

Group Name: _____Group #: _____

Insurance Phone #: _____ Claims Address: _____

_____

How would you like to be contacted to confirm all future appointments:

- ☐ Cellular phone #_____
- ☐ Home phone #_____
- ☐ Work phone #_____
- ☐ E-mail address_____

Note: All appointments must be cancelled 24 hours in advance. Last minute cancellations and missed appointments will be subject to a fee of $75.00. The fee will be collected prior to your next appointment.

_____ _____

Signature of Parent of Guardian Date

CHILDREN'S MEDICAL HISTORY EVALUATION

Patient's Name_____ Date of Birth _____/_____/_____
Last First

Physician's Name: _____ Telephone: ( ) _____

Please circle YES or NO for the following questions:

1) Is this your child's first visit to a dentist? YES NO

2) Date of last visit to a dentist _____

3) How is your child's attitude to dentistry _____

4) Purpose of today's visit? _____

5) Does your child have any medical or physical problems? YES NO

If YES, what? _____

6) Is a physician treating your child now for a specific illness? YES NO

7) Is your child taking any medication at this time? YES NO
If YES:

DRUG	WHY?
_____	_____
_____	_____

8) Does your child have any allergies to Medicines, Food, or other Substances? YES NO

If YES, to what? _____

9) Has your child ever taken Penicillin? YES NO

If YES, was there a problem? _____

10) Has your child ever bleed excessively from a cut or tooth extraction? YES NO

11) Has your child ever been in a hospital? YES NO

If YES, when? _____ Where? _____

Why? _____

12) Does your child have any of the following conditions?

AIDS	YES	NO	Heart murmur	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO
Autism	YES	NO	HIV Infection	YES	NO
Bleeding Problem	YES	NO	Kidney Disease	YES	NO
Blood Transfusion	YES	NO	Learning Problem	YES	NO
Brusing problem	YES	NO	Liver Disease	YES	NO
Brain Injury	YES	NO	Mental Retardation	YES	NO
Cancer	YES	NO	Physical Disability	YES	NO
Cerebral Palsy	YES	NO	Pregnancy	YES	NO
Diabetes	YES	NO	Psychiatric Disorder	YES	NO
Drug or alcohol abuse	YES	NO	Rheumatic Fever	YES	NO
Emotional Problems	YES	NO	Seizures/ Epilepsy	YES	NO
Eye Problems	YES	NO	Sickle Cell Disease	YES	NO
Hearing Loss	YES	NO	Speech Difficulties	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO

13) How are you related to this child? _____

Signature _____ Date: _____

Dentist's Signature _____ Date: _____

Beverly Dentistry | McLean, VA P|703.752.2200 F|703.752.2201 • Washington, DC P| 202.331.3474 F|202.331.3475
www.BeverlyPedo.com

Beverly Dentistry Financial Policy

As you already know, our practice does not participate with any insurance companies. However, as a courtesy to you, we are more than happy to submit claims on your behalf at the time of each visit. That being said, **you and not your insurance carrier, are ultimately responsible for payment of services rendered in our office.**

What can you expect at your first visit?

Although we will submit a claim to your insurance company for your first visit, you will be responsible for the entire cost of that visit.

All visits to follow:

- If your dental insurance reimburses you directly, 100% of the fees for services rendered that day are due to our office upon check-out.
- If your dental insurance does not cover treatment expenses due to our not being participants, 100% of the fees for services rendered that day are due to our office upon check-out.
- If your dental insurance reimburses our office directly, you will be responsible for the percentage that is not covered by your insurance company. Please be advised that if we do not receive a payment from the insurance company within 30 days of submission, a statement will be mailed to you. Depending on the amount we receive from your insurance company, we will then reimburse you for any excess balance on your account. If you so choose, excess balance can remain on the account for future visits as a credit. A monthly service charge of 3% will be added to accounts 30 days past due, and accounts 60 days past due will be submitted to Collections. This increase will go into effect 30 days after insurance has issued reimbursement.
- If you are a federal employee, 100% of the fees for services rendered that day are due to our office upon check-out.
- If you fail to pay the balance on your account within 60 days after the service is rendered your account will be forwarded to a collection agency and you will be responsible for all the fees of any collection agency at a percentage of 30% of the debt in addition to the original debt and all other costs and expenses including reasonable attorneys' fees incur in such collection efforts.
- In case your insurance company does not pay our office it would be your responsibility to contact them and resolve the issue not our practice.

Please ask our staff to explain our office policy regarding Nitrous Oxide, orthodontic treatment, oral sedation, and hospital cases.

It is my understanding that failure in keeping my account current will result in my account being forwarded to a collection agency. In addition, I am responsible for any collection and legal fees associated with failure to pay my bill. A fee of $75.00 will be charged for any missed appointments or appointments which are not cancelled 24 hours in advance.

_____

Signature of Parent/Guardian Date

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)

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 04-14-2003, 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 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.___ 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.

Contact: Dr. Mohammadi
mmohammadi@beverlypedo.com

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VA address: 1363 Beverly Rd, Ste 250 McLean, VA 2210 Tel: (703)752-2200 Fax: (703)752-2201