KONDAS
dental group

LIVE YOUR SMILE

Practice Agreement

*"We at **KONDAS Dental Group** are dedicated to providing you a state of the art, highly skilled dental practice that accommodates to the highest levels when it comes to our patient's individual needs and expectations. Your suggestions and recommendations are always welcome and appreciated, so please feel free to share them with us."*

Methods of Payment

Your smile is your best accessory and worth investing in, therefore, we offer several payment options so that you can customize your payments to fit your budget. **Payment Options:** Cash and Personal Checks, Credit Cards, Payment Plans that offer from 3 up to 24 months same as cash and low interest extended payment plans.(see conditions to apply)

Insurance

The original purpose of insurance (Dental Benefits) was to supplement unforeseen expenses, not to dictate treatment. Our practice is committed to providing excellent treatment for our patients and the belief is that our fees are where they should be in order to provide that service. Please understand that it is our job to treat your dental needs without the burden of worrying about whether our treatment will fit into the realm of what your insurance company deems necessary.

- We recommend treatments that we feel are necessary based on your desires, the overall welfare of your mouth and your health, not the insurance company's. Some procedures may be covered, but some may not be covered at all. We do understand that it is your decision to choose dental treatment, but we cannot be held responsible for the fact that your dental benefits may not cover what is best for you.
- We make every attempt to verify your dental benefit coverage prior to starting treatment. However, it is your dental policy and you are ultimately responsible for knowing your benefits and coverage. This is for your benefit so that misunderstandings between you and your insurance company are not an expensive surprise.
- We accept assignment of dental benefits directly, to avoid you from paying the entire expense up front. However, all estimated patient portions and deductibles are due prior to treatment.
- The account balance is your responsibility whether your insurance company pays or not. Your dental benefit policy is a contract between you, your employer and your insurance company. We are not a party to that contract; therefore we have very little leverage in getting them to pay us. You and your employer are their clients and they respond to requests by you much more favorably.
- We are happy to assist you in understanding your coverage to maximize your benefits and minimize your personal expenses as much as possible, but **if your insurance company has not paid on your account within 30 days, the account balance will be automatically be transferred to you.** The insurance commissioner states that 60 days is more than sufficient time for an insurance company to make a payment on dental treatment that is listed as a benefit in their contract with you.
- What does it mean when your insurance company states the dentist's fees "exceed usual, customary and reasonable rates (UCR)?" It usually means that your insurance benefits are too low. If you have a more expensive policy, the insurance company will often pay a higher amount. A lower premium plan such as a PPO or a HMO may severely restrict the level of treatment that your dentist can afford to provide.
- Kondas Dental Group is a preferred provider for some insurance companies **but** once you have used your annual dental benefit maximum, we will no longer make adjustments to these fees. We reserve the right **not** to make any adjustments to fees for some specific dental procedures and/or providers.

Regarding Minor Patients

The person bringing the minor child to the appointment is responsible for paying any estimated patient portion, deductibles, and balances at the time services are rendered, this does include minors of separated or divorced parents. Unaccompanied minors: Pre-arrangements for payment of estimated 0patient portion, deductibles, and balances must be made in advance. **Full Time Students** must provide a copy of their school schedule for the current quarter. Failure to do so may result in denial of benefits. **Unaccompanied Minors** will be denied treatment unless a current Medical History is on file and signed by the parent or legal guardian.

Broken Appointments

We schedule your appointment so that the time is reserved for you. We do not double book our patients;
therefore, we reserve the right to charge for cancelled or broken appointments without the required notice of cancellation.

- **I hereby authorize Kondas Dental Group to send me via e-mail my outstanding statements _____** (patient's Initials)

"In consideration of services rendered, I understand and agree that regardless of my insurance status, I am responsible for the balance of my account. In the event the account would be sent to a collection agency or small claims court due to non-payment of the account balance, I understand that I am responsible for all billing fees ($10.00 every 30 days), interest charges (21%) and any fees associated in the collection efforts of the debt (balance), including those incurred from a collection agency or small claims court."

Responsible Party (Print)	Responsible Party Signature	Date

Minor/Other Family Members covered by this agreement	
1.	2.
3.	4.

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Patient Information Form

Please complete the form in full, paying special attention to the items in red. Thank You.

About You *(Patient Information Confidential)*			
Last Name	First Name	MI	
Date of Birth	SSN	Driver's License #	
Address	City	State	Zip
Home Number ( )	Mobile Number ( )	Work Number ( )	
E-mail Address	Best Way to Reach You □ Home Number □ Mobile Number □ Work Number □ E-mail		
Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated			
Patient's Employer Information			
Employer		Work Number	
Address	City	State	Zip
If a student, name of School/College		□ Full Time □ Part Time	
Spouse/Parent's Employer			
Employer		Work Number ( )	
Address	City	State	Zip
Person to contact in case of emergency		Phone Number ( )	
Whom may we thank for referring you to our office?			
□ Current Patient (Name) _____ □ Family Member (Name) _____ □ Local Yellow Pages □ Dayton Yellow Pages □ Yellow Book □ Local Newspaper □ St. Peters School or Church □ Military □ Internet □ Drive By / Sign □ Insurance Company □ Self □ Other _____			
Responsible Party (If under 18 years of age)			
Person responsible for this account	Relationship to Patient □ Spouse □ Self □ Mother □ Father □ Stepmother □ Stepfather □ Guardian		
Address	City	State	Zip
Home Number ( ) Email:_____	Date of Birth	Driver's License #_____ SS#_____	

Insurance Information			
Name of Insured			
Date of Birth	SSN	Relationship to Patient	
Name of Employer		Work Number ( )	
Address	City	State	Zip
Insurance Company	Group #	Policy/ID #	
Mailing Address of the Insurance Company	City	State	Zip
Do you have additional insurance? □ Yes □ No If yes, complete the following:			
Name of Insured			
Date of Birth	SSN	Relationship to Patient	
Name of Employer		Work Number ( )	
Address	City	State	Zip
Insurance Company	Group #	Policy/ID #	
Mailing Address of the Insurance Company	City	State	Zip

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Patient Medical & Dental History

Patient's Last Name	Patient's First Name	Today's Date

Medical History

Physician	Office Phone Number	Date of Last Exam
	( )	/ /

Are you under medical treatment now? □ Yes □ No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? □ Yes □ No
If yes, please explain: _____

_____

Are you taking any medication(s) including non-prescription medicine? □ Yes □ No
If yes, please list in detail on the back.

Have you ever taken Phen-Fen/Redux/Fosamax? If yes, please list on the back. □ Yes □ No

Do you use tobacco? □ Yes □ No

Do you use controlled substances? □ Yes □ No

Do you snore? □ Yes □ No

Has anyone ever told you that you quit breathing during your sleep? □ Yes □ No

Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	□ Yes □ No
Penicillin or other Antibiotics	□ Yes □ No
Sulfa Drugs	□ Yes □ No
Barbiturates	□ Yes □ No
Sedatives	□ Yes □ No
Iodine	□ Yes □ No
Aspirin	□ Yes □ No
Any Metals (e.g. nickel, mercury)	□ Yes □ No
Latex Rubber	□ Yes □ No

Other: _____

Women Only:

Are you pregnant or think you may be pregnant?	□ Yes □ No
Are you nursing?	□ Yes □ No
Are you taking oral contraceptives?	□ Yes □ No

Do you have or have you had any of the following?

AIDS or HIV	□ Yes □ No	Hay Fever/Allergies	□ Yes □ No	Respiratory Problems	□ Yes □ No
Anemia	□ Yes □ No	Heart Attack	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Angina	□ Yes □ No	Heart Disease	□ Yes □ No	STDs	□ Yes □ No
Arthritis	□ Yes □ No	Heart Murmur	□ Yes □ No	Stomach Ulcers	□ Yes □ No
Asthma	□ Yes □ No	Hepatitis/Jaundice	□ Yes □ No	Stroke	□ Yes □ No
Bleeding Disorder/Clotting	□ Yes □ No	High Blood Pressure	□ Yes □ No	Swollen Ankles	□ Yes □ No
Cancer	□ Yes □ No	Joint Replacement	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cardiac Pacemaker	□ Yes □ No	Kidney Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes	□ Yes □ No	Leukemia	□ Yes □ No		
Easily Winded	□ Yes □ No	Liver Disease	□ Yes □ No		
Emphysema	□ Yes □ No	Low Blood Pressure	□ Yes □ No		
Epilepsy/Convulsions	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No		
Fainting/Seizures	□ Yes □ No	Radiation Therapy	□ Yes □ No		
Frequently Tired	□ Yes □ No	Recent Weight Gain	□ Yes □ No		
Glaucoma	□ Yes □ No	Recent Weight Loss	□ Yes □ No		

Other: _____
_____
_____

Dental History

Name of Previous Dentist	Location of Previous Dentist	Date of Last Exam
		/ /

Do you suffer from any dental anxieties?

Do your gums bleed when brushing/flossing?	□ Yes □ No
Are your teeth sensitive to hot and cold?	□ Yes □ No
Are your teeth sensitive to sweet or sour?	□ Yes □ No
Do you feel pain to any of your teeth?	□ Yes □ No
Do you have any sores or lumps near your mouth?	□ Yes □ No
Have you had any head, neck or jaw injuries?	□ Yes □ No
Have you ever experienced any of the following problems in your jaw?	
Clicking	□ Yes □ No
Pain	□ Yes □ No
Difficulty opening or closing	□ Yes □ No
Difficulty chewing	□ Yes □ No

Do you have frequent headaches?	□ Yes □ No
Do you clench or grind your teeth?	□ Yes □ No
Do you bite your lips or cheeks?	□ Yes □ No
Have you had difficult extractions in the past?	□ Yes □ No
Have you had any prolonged bleeding following extractions?	□ Yes □ No
Have you had orthodontic treatment?	□ Yes □ No
Do you wear dentures or partials?	□ Yes □ No
If yes, date of placement: _____	
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□ Yes □ No
Do you like your smile?	□ Yes □ No

Authorization and Release: *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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. It is my responsibility to inform the dental office of any changes with my medical status.*

Signature of Patient or Parent _____ Date _____

Patient's Initials/Witness/Date	Patient's Initials/Witness/Date	Patient's Initials/Witness/Date	Patient's Initials/Witness/Date

Current Medications List

For us to better provide for you, please list any and all current medications and give as much detail as possible, including vitamins and other over-the-counter aids.

Name of Medication	Dosage/mg	How many?	Condition	Length of Time on Medication
MORNING				
Example: Zocor, simvastatin	*40 mg*	*1 pill*	*High cholesterol*	*2 years*
AFTERNOON				
EVENING				
BEFORE BED				

List of Herbal Supplements/Vitamins		
Name of supplement	**Dosage:**	**Uses:**

Please list any known allergies:

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Health Insurance Portability and Accountability Act (HIPAA)

SECTION A: Patient Giving Consent			
Last Name	First Name	MI	
Address	City	State	Zip
Telephone ( )	E-mail Address		

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: Amber Morrett
Telephone: (937) 236-2800
Fax: (937) 236-3667
E-mail: thepractice@kondasdental.com
Address: 8708 Old Troy Pike, Huber Heights, OH 45424

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 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 to Patient: _____

Patient: *You are entitled to a copy of this consent after you sign it.* ***Practice Staff:*** *Include a signed copy 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: _____

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Composite Consent Form

I, the undersigned, understand that YOUR INSURANCE COMPANY reimburses posterior composite (white/tooth colored) fillings at the same amount amalgam (silver) fillings are benefited for the same teeth.

I, the undersigned, also understand as well as my insurance, that often times it is the preference of the patient and/or the treating dentist to utilize composite materials. Under these circumstances, I, the undersigned, accept the additional financial responsibility for placement of posterior composites. My actual cost will be determined by deducting the insurance payment amounts from the total charge.

Patient Name (print)	Patient Signature (parent signature in minor)	Date of Service

This also includes the following family members:

_____ _____

_____ _____

Instructions for utilizing this Authorization

- An authorization is required prior to completing posterior composites for which the patient has accepted additional financial responsibility. It is not necessary to complete a form for subsequent appointments if the member remains in agreement. ***Note:*** For children under the age of 18, the agreement must be made with the responsible parent/guardian.
- It is the responsibility of the participating dentist/office to maintain a written authorization if the patient's record. A copy of the authorization will only be requested by your insurance if the member contests the processing of the claim.
- When submitting the claim for processing, a notation referencing the authorization is required. It may be as simple as "Patient Agrees" or may be more detailed, especially if prepared statement has already been in use.

office 937.236.2800 | fax 937.236.3667 | 8708 Old Troy Pike, Huber Heights, Ohio 45424 | www.kondasdental.com

Smile Evaluation

Name: _____ Date:_____

Our office believes in involving you in your care every step of the way, since your smile belongs to you! We invite you to take part in your exam and treatment; this will help us to better treat you. Please take a moment and answer the following questions and note any esthetic concerns you may have.

Please circle your answers

Are you self-conscious of your teeth and/or smile?	Yes No
Has anyone *(family, friends, etc.)* ever suggested that you should improve your teeth or smile?	Yes No
Do you avoid smiling when you have your picture taken?	Yes No
Would you like to improve your existing smile?	Yes No
Do you have spaces between your teeth that bother you?	Yes No
Are your teeth crowded?	Yes No
Are you interested in straighter, whiter teeth without the hassle of metal brackets or wire?	Yes No
Do you snore?	Yes No
Has your snoring bothered other people?	Yes No
Has anyone ever told you that you quit breathing during your sleep?	Yes No
Are you concerned with wrinkles and would be interested in hearing more about facial rejuvenation using Botox or other derma fillers?	Yes No
Are you concerned about the appearance of your skin? If yes, would you like more information about Obagi®, a medical grade skin care line?	Yes No Yes No

What concerns do you have regarding dental treatment to improve your smile?

□ **Fear of Treatment** □ **Time of Treatment** □ **Financial**

□ **Distance to Office** □ **Understanding Treatment** □ **Embarrassment**

□ **Other**_____

□ **Not Applicable** _____

Notes: _____

_____