Kids Dentistry & Orthodontics
Tots To Teens™
& In Bee-Tween!
Over 20,000 Bee-utiful Smiles

2137 Highway 35, Suite 240, Holmdel, NJ 07733
www.TTTKids.com info@TTTKids.com
(T) 732-739-3535 (F) 732-739-1491

OFFICE POLICY REGARDING PAYMENT OF SERVICES

In order to establish optimal relations with our patients and to avoid misunderstandings regarding our payment policies, we ask you to read and sign the following:

Payment is due at the time of service unless we accept assignment with your insurance company.

If we accept assignment with your insurance company, it is your responsibility to provide the receptionist with all the necessary information needed to process your claim, including but not limited to:

1. Copy of valid insurance card
2. Subscriber's name, birth date, social security number, driver's license number and ID number

If any of the above information is not available at the time of your visit, we may reschedule your appointment until the information requested is provided.

If we work with your insurance, and any treatment is needed, we require a payment of 20% to 30% (depending on your insurance) towards the cost of your treatment on the day of the visit.

After a claim is processed by your insurance company, we will bill you for any balance due to this office, such as deductibles, co-payments, and co-insurance balances, which are to be paid within 30 days of billing. Accounts with an unpaid balance over 60 days will accrue 1.33% interest monthly unless special payment arrangements are made, or needed. After 3 billing cycles with no contact from you, the balance may be applied to your credit card, according to the individual circumstances. If the account goes into collection, a 30% collection fee will be applied to balance.

If our office is not notified 24 hours prior to cancellation of an appointment, there will be a broken appointment fee of $50.00, except in the case of any emergency.

Your signature below indicates that you understand and accept this policy. Furthermore, your signature authorizes this office to release dental information necessary to process your insurance claims and allows the use of "signature on file" in lie of your signature. You herein authorize payment of dental benefits to this office.

_____ A/C # _____ _____Date

Signature

"Dr. B"
Jayati C. Bhattacharyya, DDS*
Pediatric Dentist
NJ Spec. Permit #5825

Amy Lin, DDS*
Pediatric Dentist
NJ Spec. Permit #5863

Sonalee P. Kapoor, DMD
Exclusively Orthodontics
NJ Spec. Permit #5443

Joana M. Brown, DMD
Pediatric Dentist
NJ Spec. Permit #6774

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Today's Date _____ Acct. # _____

Patient's Name _____ Nickname _____ Sex _____ Birthdate _____ Age _____

Address _____ City _____ State/Zip _____/_____ Phone ( ) _____

Primary Parent name _____ Secondary Parent name _____

Child lives with _____

Referred by: Name _____

Primary Parent Information

Mr. Mrs. Ms. Dr. Rev.

Last _____ First _____

Social Security # _____

Driver's License # _____

Birthdate _____

Address _____

City _____ State/Zip _____/ _____

Phones: Home # ( ) _____

Cell # ( ) _____

Relationship to Patient _____

Email _____

Secondary Parent Information

Mr. Mrs. Ms. Dr. Rev.

Last _____ First _____

Social Security # _____

Driver's License # _____

Birthdate _____

Address _____

City _____ State/Zip _____/ _____

Phones: Home # ( ) _____

Cell # ( ) _____

Relationship to Patient _____

Email _____

Employer Information

Company Name _____

Address _____

City _____ State/Zip _____/ _____

Phone ( ) _____

Dental Insurance Information

Company Name _____

Address _____

City _____ State/Zip _____/ _____

Phone ( ) _____

Employer Information

Company Name _____

Address _____

City _____ State/Zip _____/ _____

Phone ( ) _____

Dental Insurance Information

Company Name _____

Address _____

City _____ State/Zip _____/ _____

Phone ( ) _____

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Patient's name _____

Medical History

Physicians's Name _____ City_____ State/Zip _____ Phone ( )_____

Patient's Health _____ Last Physical Check-Up _____

Medication taken by patient _____

Has Patient ever been hospitalized _____ Why? _____When? _____

Please indicate any of the following that pertains to the patient

Anemia	Cerebral Palsy	Epilepsy	Heart Murmur	Neurological Disorders
Asthma	Convulsions	Fainting Spells	Hepatitis/AIDS	Rheumatic Fever
Autism	Diabetes	Hearing Problems	Kidney Problems	Speech Problems
Blood Disorder	Emotional Disorders	Heart Condition	Liver Condition	Unusual Bleeding
				Other

Please give details _____

_____

Please list any allergies the patient may have to any medications, foods, substances, latex, etc. _____

Any complications of mother's pregnancy with this child? _____

Dental History

Reason for visit (toothache, check up, bad experience, emergency) _____

Is this the patient's first visit to the dentist? _____

If not, please provide previous dentist's name, address, and telephone _____

_____

What was the patient's experience at previous dentist? _____

When were Radiographs (X-rays) last taken? _____ By whom? _____ How often does patient brush his/her teeth?

Is your child taking a fluoride or fluoride-vitamin supplement? ▫ YES ▫ NO Which one? _____

Has your child ever been put to bed with a bottle? ▫ YES ▫ NO

Would you want to have brushing instructions for the patient? ▫ YES ▫ NO

Has there ever been an injury to the mouth or teeth? ▫ YES ▫ NO

Does the patient have any oral habits? ▫ YES ▫ NO

▫ Thumbsucking ▫ Mouth Breather ▫ Nail Biting ▫ Tongue Thrusting ▫ Other _____

Do you help your child (under age 6) brush? ▫ YES ▫ NO

Did mother or father have orthodontics (braces)? ▫ YES ▫ NO

Do you have any questions that you would like to have answer? ▫ YES ▫ NO

Patient's interests, hobbies, talents, likes, dislikes, etc. _____

Names and Birth dates of other children:

1._____ _____ 3._____ _____

2._____ _____ 4._____ _____

I, being the (father, mother, guardian) of the above named patient, hereby give my consent for all necessary dental services including necessary medications. I will be responsible for the fee incurred for treatment rendered and I understand ALL balances are my responsibility and must be paid within 60 days or interest will accrue. I understand my credit card on file will be used if the account becomes delinquent, unless payment arrangements are agreed upon.

credit card # _____ expiration date _____ 3-digit code _____ zip code _____

If the account goes into collection, an additional 30% charge will be added to account balance. I have been advised of this office's Notice of Privacy Practices and understand a copy is available at my request.

Signature _____ Date _____

IMPORTANT: Please inform our office prior to any visit of any change in health and medications taken by the patient. Thank You.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [EDIT: [we will] [we usually will not]] ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited

situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.