-

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

# Welcome To Our Practice!

Date____________________

### PATIENT INFORMATION

Name________________________________________ Preferred name__________________

Date of Birth_____________________

Phone Numbers: Home______________ Cell_______________ Work___________________

Email_______________________________________________________________________

Would you like to receive email confirmations? YES NO

Address________________________________________ City___________________________

State_______________ Zip Code______________ SS#________________________________

Your Employer________________________________________________________________

Please circle one: Minor Single Married Divorced Widowed Separated

Spouse or Parent/Guardian's Name______________________________________________

Whom may we thank for referring you? __________________________________________

Person to contact in case of emergency__________________________________________

Phone Number_____________________________________

Name of your primary physician _______________________________________________

### RESPONSIBLE PARTY (If other than patient)

Name of Person Responsible for Account__________________________________________

Relationship to Patient_________________________________________________________

Date of Birth______________________________ SS#_______________________________

Address____________________________________________ City_____________________

State____________________ Zip Code______________________

Phone Numbers: Home________________ Cell________________ Work________________

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

## INSURANCE INFORMATION

Name of Insured_______________________________________________________________________

Name of Insured's Employer_____________________________________________________________

Date of Birth_________________________________ SS#____________________________________

Phone Numbers: Home____________________ Cell__________________ Work_________________

Insurance Company_____________________________________________________________________

Claims Address___________________________ City____________________ State____________

Zip Code_________________

Group Number________________________ Insurance ID# _________________________________

Annual Maximum Benefit_________________________ Annual Deductible___________________

How much of your annual benefit have you used so far this year?_________________________

Relationship to Patient_________________________________________

**Do you have additional insurance? YES NO If so, please complete the following:**

Name of Insured_______________________________________________________________________

Name of Insured's Employer_____________________________________________________________

Date of Birth_________________________________ SS#____________________________________

Phone Numbers: Home____________________ Cell__________________ Work_________________

Insurance Company_____________________________________________________________________

Claims Address___________________________ City____________________ State____________

Zip Code_________________

Group Number________________________ Insurance ID# _________________________________

Annual Maximum Benefit_________________________ Annual Deductible___________________

How much of your annual benefit have you used so far this year?_________________________

Relationship to Patient_________________________________________

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

***OFFICE FINANCIAL POLICY***

***Payment is due at the time services are rendered.*** *For your convenience we accept cash, Visa, MasterCard, American Express, personal check, money order, or registered check.*
***Insurance benefits are determined by your employer and not your dentist****.*
***Any deductible or estimated co-payment amount will be due at the time of treatment.***
*Insurance is not a guarantee of payment; insurance companies will not pay of all of your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance wallet card and 2) all required employer information.* ***You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment.***
***If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.***
*We reserve the right to charge and collect fees for broken appointments—appointments that are cancelled or broken without 24hrs advance notice. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.*
***Returned Check Fee*** *of $40.00 will be added to your account balance and is collectible.*
***Payment plans and financial arrangements*** *can be entered into for comprehensive dental treatment, prior to commencing treatment.*
*Courtesies cannot be combined and are not to exceed 10%.*

***I have read and understand this financial policy.***

____________________________________ ____________________________________

PRINTED NAME SIGNATURE

____________________________________ ____________________________________

DATE WITNESS

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

**PATIENT MISSED APPOINTMENT AGREMENT**
**FOR THE OFFICE OF BRAD JUDY, DDS**

Trying to accommodate every patient's individual needs and work schedules can be difficult but we always try to do our best. We work very hard to stay on schedule so that our patients will not spend too much time in our reception area waiting for their appointments.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time, as you selected, just for you. When an appointment is missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur and we always take that into consideration when receiving a last minute cancellation.

If you find that you cannot keep your scheduled appointment, we ask that you provide a minimum notice of **twenty-four business hours**. This time allows us to schedule another patient in the need of treatment. We are closed on Saturday and Sunday, so Monday cancellations must be made prior to Friday. Failure to do so may result in a missed appointment fee of $100.00 per each hour of the appointment that is scheduled.

From the date of this agreement, each family is entitled to three missed appointment in the life of the relationship with the practice. After three missed appointments, our office will visit with you regarding our relationship and determine if your dental needs might be better served by another provider. We may alternatively determine that it will be necessary for you to prepay for the service that will be rendered at your ensuring appointment.

If you have any questions, please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

Patient Signature:____________________________________________________ Date:________________________

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

## ACKOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

Brad Judy, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, you will be offered a copy of the revised Statement of Privacy Practices at the time of your first visit after the revisions are in effect. You may also obtain a revised Statement of Privacy by requesting that one be mailed to you.

## ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

| | | |
|---|---|---|
| ANY MEMBER OF MY IMMEDIATE FAMILY | ( ) YES | ( ) NO |
| SPOUSE ONLY | ( ) YES | ( ) NO |
| OTHER (PLEASE SPECIFY) ________________________ | ( ) YES | ( ) NO |

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Brad Judy, DDS. The Statement of Privacy Practices describes the types of uses and the disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and the duties of this office with respect to my protected health information.

________________________________________ ________________________________________

**Name of Patient** *or personal representative* **Signature of Patient** *or personal representative*

________________________________________ ________________________________________

**Date** *Description of Personal Representative's Authority*

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

## X-RAY RELEASE FORM

I authorize ________________________________________ to release any dental records and/or x-rays to Dr. Brad Judy, DDS, PLLC.

Name of Patient: ______________________________________

Name of Patient: ______________________________________

Name of Patient: ______________________________________

Name of Patient: ______________________________________

**Please send digital records to:**

Admin@bradjudydds.com

**Please send hard copies to:**

Dr. Brad Judy, DDS

3236 78th Ave SE Suite 106

Mercer Island, WA 98040

206-232-5866

Signature_____________________________________________ Date_____________________________________

3236 78th Ave SE, Suite 106
Mercer Island, WA 98040
206-232-5866
bradjudydds.com

## *STATEMENT OF PRIVACY PRACTICES*

*Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal value of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.*

***Protecting Your Personal Healthcare Information,***

*We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone -even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.*

***Collecting Protected Health Information,***

*We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.*

***Disclosure of your Protected Health Information***

*As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, email and postcards.*

***Patient Rights***

*You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.*

*We thank you for being a patient of Dr. Brad Judy. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.*