Leesburg FAMILY DENTAL

Dr. Talib Ali DMD | Dr. Ali Mualla DDS

Patient's Name_____ Social Security #_____

Gender _____ Birthdate_____ Email Address_____

Home Address _____City _____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Emergency Contact Name _____ Phone Number _____

Primary Pharmacy Name & Location _____ Phone Number _____

How did you hear about our office?

(Please select all that apply)

yelp ☐ Zocdoc ☐ YAHOO! ☐ Google ☐ bing ☐ ☐ ☐

A friend (name): _____ ***Other:*** _____

Office Policy

Thank you for choosing Leesburg Family Dental as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, MasterCard, Visa, Discover, American Express, and Care Credit. Outstanding financing (payment plans) is available upon request and approval.

Please Note: Returned checks will be subject to additional fees. In the care, it becomes necessary for our service to enlist a collection of service and/ or legal assistance, you will be responsible for any collection and/or legal charges up to 35%

- We strive to render excellent dental care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when its missed, that time cannot be used to treat another patient. We ask that you give our office 48 hours' notice (if calling on a day that the office is closed, a voicemail with your name and appointment date and time is required to properly cancel) if you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time or do not show up for your appointment, this is considered a missed appointment. A fee of $100.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled no can records be transferred without the payment of this fee. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $100.00 cancellation fee will be charged. After missing three appointments with or without notice, you may be placed on a same day scheduling policy for treatments, which would not allow you to schedule any appointments in advance. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.
- We thank you for your patronage. I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationships with you, our patient, not your insurance company. Your insurance policy is contract among you, and your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, MasterCard, Visa, Discover, American Express, or Care Credit at the time we provide the service to you.
- Insurance Payments are ordinarily received within 30-60 days of the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter a dispute with your insurance company over any claim.
- Thank you for choosing Leesburg Family Dental as your dental care provider. We are committed to providing you with the affordable and highest quality lifetime dental care.
- Payment is due at the time of service provided.
- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not guaranteed that your insurance will pay exactly as estimated. Any part of your bill not covered by your insurance or denied payment will be your responsibility.
- **Consent: I _____, have read, understood, and agreed to the terms and conditions listed above.**

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care of our financial policy.

CONSENT: I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and/or attorney fee will be added to any overdue balance.

CONSENT: I authorize Leesburg Family Dental and its' staff to take X-Rays and Photos to aid in diagnosis and/or for my treatment.
By signing below, you are authorizing us to call you and/or email you at any number/email you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an upcoming call from us, and/or outgoing calls to us, to or from and such number, without reimbursement from us.

Patient and/or Guardian Signature: _____ **Date:** _____

Leesburg
FAMILY DENTAL

Missed Appointment / Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when its missed, that time cannot be used to treat another patient. We ask that you give our office 48 hours' notice (if calling on a day that the office is closed, a voicemail with your name and appointment date and time is required to properly cancel) if you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time or do not show up for your appointment, this is considered a missed appointment. A fee of $100.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled no can records be transferred without the payment of this fee. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $100.00 cancellation fee will be charged. After missing three appointments with or without notice, you may be placed on a same day scheduling policy for treatments, which would not allow you to schedule any appointments in advance. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

Please initial amongst the following lines below

_____ I understand that If I am unable to keep my appointment I am required to call at least 48 hours prior to my given appointment time to avoid a missed appointment fee of $100.00 (excluding holidays)

_____ I understand that late cancellations, no shows, and late arrivals after 20 minutes will result in a missed appointment fee of $100.00.

_____ I understand that I am responsible of all missed appointment fees are my full financial responsibility and that my insurance company is not responsible for / will not pay for any missed appointment fees in which I incur.

_____ I understand that if I contact Leesburg Family Dental in regard to cancelling my appointment before the 48-hour cut off time and I am not able to speak with a front desk coordinator, I will leave a voicemail in regard to cancelling my appointment to ensure proper cancellation.

_____ I understand that after missing and/or cancelling 3 appointments, I may be placed on a same day scheduling policy for treatments. Which would not allow me to schedule any appointments in advance.

_____ I understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice

Signing below indicates that you understand and agree to the terms of this policy

_____ _____

Signature of Patient Date

Leesburg FAMILY DENTAL

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

DENTAL HISTORY

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

_____

The most important concerns regarding your dental visit today is:

_____

_____

MEDICAL HISTORY

☐Y☐N Under a physician's care now? If Yes, Explain:

☐Y☐N Any hospitalization in the past 5 years? _____

☐Y☐N Any serious illnesses/surgeries? If Yes, Explain: _____

☐Y☐N Use tobacco in any form? If Yes, Explain:

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) IF NONE, CHECK "NONE": ☐NONE

☐ALLERGIES (SEASONAL)	☐CERVICAL CANCER	☐HEARING PROBLEMS	☐RESPIRATORY DISEASE
☐ANGINA (CHEST PAIN)	☐CHEMOTHERAPY	☐HEART ATTACK	☐RHEUMATIC FEVER
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐STOMACH PROBLEMS
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐SLEEP APNEA
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CORTISONE MEDICATION	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐CONVULSIONS	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐LOW BLOOD PRESSURE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐PREGNANT (CURRENTLY)	☐VENEREAL DISEASE
☐BRUISE EASILY	☐FREQUENT HEADACHES	☐PACEMAKER	
☐CANCER	☐GLAUCOMA	☐OTHER – PLEASE LIST: _____	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO ANY MEDICATIONS? (IF YES, PLEASE EXPLAIN):

Patient Signature: _____ Date: _____ Dentist Signature: _____

Leesburg
FAMILY DENTAL

Photography Release and Consent Form

Marketing/Educational Consent

Following clinical purposes as indicated by my signature below:

- I understand that such photographs, videos or case histories may be published by Leesburg Family Dental and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, training manuals, presentations and teaching courses, books, magazines, and internet websites, for the commercial, non-profit and/or educational purpose of informing others about dental treatment methods.
- I release and discharge Leesburg Family Dental and all parties acting under their license and authority from all rights that I may have in the photograph, and from any claim that I may have relating to such use in publication, including any claim for payment about distribution or publication of the photographs.
- I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. Neither I, nor any member of my family, will be identified by name in any publication.
- I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.
- I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

PLEASE CHECK THE FOLLOWING BOX BELOW TO CONSENT OR DENY CONSENT TO THE USE OF YOUR PHOTOGRAPHS

☐ I consent to the use of my photographs, videos, or case information for the above listed clinical purposes.

☐ I deny consenting to the use of my photographs, videos, or case information for the above listed clinical purposes.

_____	_____	_____
Patient's Name (Please Print)	Signature of Patient and/or Legal Guardian	Date

Consent for use and disclosure of health information

Patients Name: _____

TO THE PATIENT, PARENT, OR GUARDIAN; PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected information to carry out treatment, payment activities and healthcare options.

Notice of Privacy Practices: You have the right to read our **Joint Notice of Privacy Practices** before you decide whether to sign this consent. Our notice provides a description of our treatment, Payment activities, healthcare operations, and how health information about you may be used and disclosed and how you can get access to this information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. You are entitled to a copy of this form if you would like one, **JUST ASK.**

We reserve the right to change our privacy practices as described in our **Notice of Privacy Practices.** If we change out privacy practices, we will issue a revised Joint 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 **Joint Notice of Privacy Practices,** include any revision of our Notice, at any time by contacting:

Leesburg Family Dental
HIPAA Compliance Office
545 G East Market Street
Leesburg, VA 20176
(703) 669-8600

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notices of your revocation submitted to the contain person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we receive your revocation, and that may decline to treat you or 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 Leesburg Family Dental use and disclosure of the patient's protected health information to carry out treatment, payment activities, healthcare operations and other uses described in the Leesburg Family Dental **Joint Notice of Privacy Practices** that was provided to me.

_____

Patient and/or Guardian Signature Date

_____

Doctor Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ Please *print* name of Patient

_____ Please *sign* Patient / Guardian of Patient

_____ Legal Representative / Guardian

_____ Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____