Office Manual

Appendices

Hillandale Smiles

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Table of Contents

Appendix 1: Internal Forms and Files

Appendix 1.1: Internal Office Forms

Insurance Verification Form

Patient Name:			Insurance Name:					
SS#: DOB:			Insurance Address: Phone #:					
Address:			Guarantor Name: DOB:					
Phone: Cell:			Guarantor ID / SS #:					
Email:			Guarantor Employer:					
Effective Date:	Yearly Max:		Used:	Deductible:		Fam. Ded.:		
PREVENTATIVE			BASIC			MAJOR		
	% Paid	Frequency		% Paid			% Paid	
Exams			Amalgams			Crowns		
BW			Composites			Onlays		
Prophy			Endodontics			Implants		
Fluoride			Periodontics			Removable		
Sealants			S/RP			Fixed Prosthetics		
Pano/FMX			Oral Surgery			Bridges		
FMD								
ORTHODONTICS:		Yearly Max:			Used:			
HISTORY:								
Date Verified:	Verified By:		Date Entered:		Entered By:			

Patient Name:			Insurance Name:					
SS#: DOB:			Insurance Address: Phone #:					
Address:			Guarantor Name: DOB:					
Phone: Cell:			Guarantor ID / SS #:					
Email:			Guarantor Employer:					
Effective Date:	Yearly Max:		Used:	Deductible:		Fam. Ded.:		
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	% Paid	Frequency		% Paid			% Paid	
Exams			Amalgams			Crowns		
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Sealants			S/RP			Fixed Prosthetics		
Pano/FMX			Oral Surgery			Bridges		
FMD								
ORTHODONTICS:		Yearly Max:			Used:			
HISTORY:								
Date Verified:	Verified By:		Date Entered:		Entered By:			

Leave Request Form

You must seek approvals for non-emergency leave, 3 days prior to your first day of absence. Your co-workers must be notified in advance.

Employee Name: Employee Signature:

□Late Arrival / Early Departure □ Other – Please Specify:
□Leave Without Pay (LWOP)
□Paid Time Off (PTO)

From Date: Returning Date:

□Approved Notes:

□Rejected _____
Supervisor Signature

□Approved Notes:

□Rejected _____
Office Manager

Leave Request Form

You must seek approvals for non-emergency leave, 3 days prior to your first day of absence. Your co-workers must be notified in advance.

Employee Name: Employee Signature:

□Late Arrival / Early Departure □ Other – Please Specify:
□Leave Without Pay (LWOP)
□Paid Time Off (PTO)

From Date: Returning Date:

□Approved Notes:

□Rejected _____
Supervisor Signature

□Approved Notes:

□Rejected _____
Office Manager

Time Clock Correction CSW

Employee Name: Today's Date:

Date of Occurrence:

Correction Needed:

- ☐ Did Not Clock In/Out
- ☐ Did Not Clock In/Out for Lunch
- ☐ Clock In:
- ☐ Clock Out:
- ☐ Clock In for Lunch:
- ☐ Clock Out for Lunch:

Explanation for Correction:

I understand that this is part of my performance evaluation:

_____ _____

Employee Signature Today's Date

_____ _____

Correction made by Correction Date

Time Clock Correction CSW

Employee Name: Today's Date:

Date of Occurrence:

Correction Needed:

- ☐ Did Not Clock In/Out
- ☐ Did Not Clock In/Out for Lunch
- ☐ Clock In:
- ☐ Clock Out:
- ☐ Clock In for Lunch:
- ☐ Clock Out for Lunch:

Explanation for Correction:

I understand that this is part of my performance evaluation:

_____ _____

Employee Signature Today's Date

_____ _____

Correction made by Correction Date

Claim Problem Report

Patient Name	Date of Service (DOS)	Unpaid > 30 days	Unsubmitted > 1 day	Action

Return Mail Form

Name	Type of Mail	Action	Re-Sent (Y/N)

Phone Record for an Emergency or New Patient

Patients name _____Age _____ Today's Date: _____ Front Desk Initial: _____
Callers name if different_____
Relationship_____

REASON FOR CALL: □Emergency □ New Patient Exam □Date of last visit_____ Patient of record □

EMERGENCY:
Chief Complaint: (area of mouth or tooth)_____

Sensitive to: □ none hot □ cold □ pressure □ biting □
Pain: yes□ no□ occasional □ constant □
Swelling: yes □ no □ where / how big? _____
Taking Pain Medication: yes □ no □ What _____

Inform patient based on this information they should set up a;

□ 1) **Scheduled emergency appointment** to evaluate and treat (minimum take out of pain) a specific complaint or problem.
- This is not an comprehensive evaluation for cavities and cleaning.
- The **estimated fee** for emergency exam, an x-ray, diagnosis and presentation of possible treatment options will be $**96.00**.
- This fees will be corrected in accordance with their dental benefits if they have any, on verification at that appointment.
- This does not include any treatment, treatment fees cannot be estimated until after the patient receives the examination and a diagnosis of their problem is made.

□ 2) **new patient exam**, this is to meet the patient review their medical history, see if they have any areas that they are concerned with, a comprehensive and detailed examination of their oral tissues, to include checking their teeth for cavities or broken filling or infection, and the gums for tarter, and gum disease. Cavity x-rays and other x-rays needed for this examination will also be taken.
- The estimated fee for this appt., including the examination, x-rays, diagnosis, and recommendations for tx. will be $**165.00**.
- This will then be corrected in accordance with their dental benefits.
- Inform pt. that no cleaning will be involved in this appt., an appropriate hygiene appointment will be arranged following this visit.

To be able to make this appt. we need some initial information.

Do you need to or have you previously taken antibiotic Premedication prior to dental appt?
- This is not antibiotics for an infection.
- This is for conditions such as a Heart murmur, Mitral valve prolapse, Rheumatic Fever, Heart valve defect.

yes □ no □ don't know □ Name of Antibiotic: _____

Do you have any Dental Insurance or Benefits: Yes □ No □ Name: _____

Background: Address _____Daytime phone: (if we can get you in earlier) _____

□ Remind patient to come in 15 minutes before appointment to fill out their patient record and medical history.
□ Also to bring in their dental insurance card and information so you can bill their insurance. We do have a general listing on how much their dental benefits will cover.
□ **All** services provided for that day can be paid by credit card, check or cash.
□ The office policy as of Nov., 94, is to bill only for outstanding balances not covered by their insurance.
□ If this appointment needs to be canceled a broken appointment fee will be assessed. This charge can be avoided if the appointment was canceled and rescheduled with a 24 hour or greater notice.

The earliest that Doctor _____ Can see you for this appointment is, Date: _____Time: _____

Canceled Appointment: _____ Rescheduled Appointment: _____
Other notes:

Appendix 1.2: RCF Forms

ADULT TREATMENT

A	___ M PRO
AE	___ M PRO, EXAM DR ____
AEX	___ M PRO, BWX EXAM DR ___
PM	___ M PERIO MAINT
01110	ADULT PROPHY
ANEW	ADULT NEW PATIENT COMP EXAM, BWX, PANO DR ___
0120	PERIODIC EXAM, DR ____
0140	LIMITED ORAL EXAM, DR ____
FMD	FULL MOUTH DEBRIDEMENT
JET	PROPHY JET
S/RP1	SC / RP 1 QUAD
S/RP2	SC / RP 2 QUAD
4342	SC/ RP 1-3 TEETH
4381	ARESTIN, PER SITE
4382	ARESTIN, PER QUAD (5-10 SITES)
CVS	ARESTIN PER SITE
CVS	ARESINT PER QUAD
D9630	DISPENSE PRESCRIPTION MEDS

CHILD TREATMENT

CNEW	CHILD COMP EX, PRO, BWX, PAN DR ___
C	CHILD ___ M PRO, FL
CE	CHILD ___ M PRO, EX, FL DR ___
CEX	CHILD ___ M PRO, EX, BWX, FL DR ___
01120	CHILD PROPHY
0220	PERIAPICAL, 1ST FILM
0230	PERIAPICAL, ADDITIONAL
0272	BITEWING, (2)
0274	BITEWING (4)
0330	PANOREX
1351	SEALANT, PER TOOTH
1204	ADULT TOPICAL FLORIDE
00431	LESION DETECTION

NEXT VISIT HYGIENE

___M PRO
___M PRO, EXAM
___M PRO, BWX, EXAM DR ____
___M PERIO MAINT

PROPHY JET
FULL MOUTH DEBRIDEMENT
SC/RP 1 QUAD + ARESTIN

SC/RP 2 QUAD + ARESTIN

SEALANT #

NEXT VISIT DOCTOR

10130	REFER ENDO
10140	REFER PERIO
10150	REFER PROSTHO
10170	REFER O.S.
10180	REFER ORTHO

UCR FEE _____ Fee w/ Ins _____ ESTD. PT PORTION _____ PREV PT BALANCE _____ AMOUNT REC + HOW _____ CKD OUT BY _____

00140	Limited Exam
00150	Comp Exam
00170	Follow up Exam
00431	Lesion Detection
00220	Periapical, 1st Film
00230	Periapical, Additional
00274	Bitewing (4)
00330	Panorex GP
00350	Photos per visit
01351	Sealant per tooth
02330	Ant Comp one surf
02331	Ant Comp two surf
02332	Ant Comp three surf
02335	Incisal Angle four surf
02391	Post Comp one surf
02392	Post Comp two surf
02393	Post Comp three surf
02394	Post Comp four surf
02642	Onlay Porc two surf
02643	Onlay Porc three surf
02910	Onlay recementation
02644	Onlay Porc four surf
02740	Crown ALL Porcelain
02752	Crown Porc - Noble Metal
02750	Crown Porc - Gold
02799	Crown Provisional
02920	Crown Recementation
02747	Gold/Capteck Sur-chrg
02748	Ceramic/Empress Sur-chrg
02749	Zirconium/Procera Sur-chrg

02950	Build Up
02954	Pre Fab Post and Core
02952	Cast Post and Core
02940	Sedative Restoration (CC)
03321	Gross Pulpal Debridement (CC)
03220	Pulpotomy Baby Tooth
02960	Veneer Chairside
02962	Veneer ALL Porcelain
03310	Anterior RCT
03320	Premolar RCT
03330	Molar RCT
05110	Denture Full- Upper
05120	Denture Full- Lower
05130	Denture Immediate- Upper
05140	Denture Immediate- Lower
05211	Upper Partial- Acrylic Base
05212	Lower Partial- Acrylic Base
05213	Upper Partial- Cast Base
05214	Lower Partial- Cast Base
06010	Implant Body Traditional
06057	Implant Custom Abutment
06058	Implant Crown All Porc

Other:

09230	Nitrous per ½ hour
09630	Dispense Med in office
10190	Prescribe Med
09110	Pallative tx for pain
09910	Desensitizing Application
4265	Biological Materials
09940	Occlusal guard
09951	Limited Occlusal Adjustment
09973	Whitening Home per arch x2
09972	Whitening ZOOM! Per arch x2
09975	Whitening Touch Up
17000	Xylimax Gum
17001	Oral B Triumph
10026	Insert fixed appliance #
10027	Deliver removable appliance
07140	Extract exposed tooth or root
07210	Surgical Extraction

Next Visit

10130	Refer	Endo
10140	Refer	Perio
10150	Refer	Prostho
10170	Refer	O S
10180	Refer	Ortho

UCR FEE _____ Fee w/ Ins _____ ESTD PT. PORTION _____ PREV PT BALANCE _____ AMNT RECD + HOW _____ CKD OUT BY _____

Contract Balance

Last Payment

Current Balance

Balance Due

Amt Rec + How

Chkd Out By

Today		Next Visit
_____	O Routine Visit	_____
_____	O Initial Exam	_____
_____	O Second Exam	_____
_____	O Records	_____
_____	O Separators	_____
_____	O Impress Appliance	_____
_____	O Dlvr Intl Appliance	_____
_____	O Invis Start	_____
_____	O Invis Rout Visit	_____
_____	O Invis Impress Second	_____
_____	O Invis End + Imp Ret	_____
_____	O Bonding 2 Arches	_____
_____	O Bonding 1 Arch	_____
_____	O Bonding 7's	_____
_____	O Deband and Imp Ret	_____
_____	O Dlvr/Check Ret < 6 mo	_____
_____	O Check Ret > 6mo ($65)	_____
_____	O LOE/Emergency	_____
_____	O Other (specify)	_____

FMD	Full Mouth Debridement
D4341	Sc / rp 4-8 teeth per quad
D4342	Sc / rp 1-3 teeth per quad
S/RP2	Sc / rp 2 quad
D4381	Arestin, per site
D4382	Arestin, per quad
D4240	Flap Sx w/o oss sx
D4260	Oss Sx 4-8 teeth per quad
D4261	Oss Sx 1-3 teeth per quad
sx c	oss sx + bone + memb
D4263	Bone graft 1st site
D4264	Bone graft each addnl site
D4267	Membrane 1st site / tooth
D4267	Membrane 2nd site / tooth
D4249	Crown Length per tooth
D4210	Gingivectomy 4 - 8 teeth
D4211	Gingivectomy 1 - 3 teeth
D4273	Sub Epi Con Tissue Graft
D4274	Distal Wedge

D0140	Limited Exam by Spec
D0180	Comp perio Exam by Spec
D0170	Follow up Exam by Spec
D0431	Lesion detection
D0220	Pa, 1st Film
D0230	Pa, Additional
D0330	Panorex by Spec only
D0210	Full mouth by Spec only
D6010	Implant Fixture
imp c	Implant Complex , bone, memb
D6056	Implant Prefab Abut
D6057	Implant Custom Abut
D6059	Implant Crown porc/gold
D7140	Ext exposed tooth or root
D7210	Ext Surgical
D7286	Biopsy, Soft Tissue
D7310	Alveoplasty Per Quad
D7950	Sinus elevation

D00Rx	Prescribe Med
D9230	Nitrous Oxide per ½ hour
D9630	Dispense Med
d4265	biological materials
Next Visit	
D0170	Post op exam

UCR fee _____ Fee w/ Ins _____ Estd Pt. Portion _____ Prev PT Balance _____ Amnt Recd + How _____ Ckd out by _____

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Date_____Signature_____

Staff Office Survey Form

Please fill out as if you were the patient. Answers are Yes, No, N/A and returned to Dr Sterling by Friday end of business.
You should elaborate with a vengeance as need.

1. Lighting *as if you were the patient*
   _____ Is there sufficient lighting in all office areas to allow staff members to function without eye strain?
   _____ Is there sufficient lighting so that all areas appear bright and not drab and dull?
   _____ Are there any burned out bulbs?
   _____ Are light bulbs and fixtures clean?
   _____ Are there any areas where the lighting is too harsh for the eyes?

(This could be the result of light being reflected from the outside and not being properly screened).

2. Decor *as if you were the patient*
   _____ Is the furniture in the reception area sturdy and easy to keep clean?
   _____ Is there adequate seating space? (Requirements are determined by the office patient flow)
   _____ Is the furniture neatly arranged?
   _____ Is the furniture torn, frayed or dirty?
   _____ Is there a place to hang coats? (hooks or hangers)
   _____ Is there an adequate number of hooks and/or hangers?
   _____ Are the hooks or hangers attractive or in good repair?

(wire hangers should be replaced with plastic or wood which give a nicer appearance in addition to being sturdier)

   _____ Is there an umbrella stand?
   _____ Is there proper security for coats and umbrellas?

(Explanation: this means within sight of the receptionist)

   _____ Is there adequate privacy for patients and receptionist to discuss business without patients in the reception area?

(Explanation: If there is not a separate area removed from the patients in the reception area, it is recommended that the patient be brought behind the receptionist's desk so that business matters can be discussed in a private manner.)

   _____ Is there sufficient privacy for the staff members behind the reception desk to work in an uninterrupted manner?

(Explanation: A counter, hinged door or sliding glass window can create a privacy effect)

   _____ Are magazines up-to-date?
   _____ Are magazines properly selected? Suggestions?

(Explanation: magazines should have appeal to all age groups. Dental technical journals or magazines depicting nudity should not be included)

   _____ Are plants being properly pruned and watered?
   _____ Are wall hangings proper, clean, straight?
   _____ Is there paint chipping?
   _____ Is wallpaper peeling?
   _____ Are carpets worn?
   _____ Are tiles or floor boards rising?
   _____ Is ceiling clean and in good repair
   _____ Is office temperature uncomfortable? (Explanation: does this occur repeatedly?)
   _____ Is there adequate insulation from noise in the laboratory and treatment areas?

(Explanation: Quite often, simply keeping the door closed or decreasing unnecessary noise can solve the problem.)

   _____ Does the restroom have a mirror, wastebasket and deodorizer or satisfactory exhaust system?
   _____ Is the overall office appearance cheerful, relaxing and inviting?

(Explanation: Are colors bright? Are there murals and plants or bright pictures on the walls? Dentistry pictures or little statues depicting needles or tooth extraction do not enhance the cheerful image.)

   _____ Are there any torn or frayed curtains or drapes?
   _____ Is the treatment conference area projecting a relaxed non-academic feeling?

3. Cleanliness *as if you were the patient*
   _____ Is equipment clean, dusted and polished?
   _____ Are blinds clean?
   _____ Are window sills clean?
   _____ Is furniture clean, dusted and polished?
   _____ Are items on tables, for example telephones, X-Ray view boxes, clean and dusted?
   _____ Are waste baskets overflowing? (Explanation: Overflowing could mean a larger basket is required.)
   _____ Are carpets clean?
   _____ Are doors, floors, walls, and switch plates clean?
   _____ Are areas under furniture clean?
   _____ Are sinks clean?
   _____ Are restroom sinks and toilets clean?
   _____ Are there sufficient towels and toilet paper in the restroom, treatment rooms and laboratory?

_____ Is soap being used throughout the office?
_____ Are examination and treatment rooms clean?
_____ Does each room smell fresh and clean, especially the restroom, treatment room and laboratory?
_____ Are dishes, cups, dirty towels, etc. being cleaned up?
_____ Are treatment room cuspidors clean? (Examined as viewed by patient)
_____ Are all areas of the treatment room being cleaned after each patient such as saliva ejectors, hand pieces?
_____ Are treatment room drapes and lead shields being carefully wiped between patients?
_____ Are all areas being touched by the doctor and assistant being properly wiped?
(Explanation: X-Ray head, switches, chair buttons, etc.)
_____ Is the dental chair being carefully checked between patients?
(Explanation: Look to be sure that there are no small pieces of alginate, dust, etc. in the creases of the chair back or arm rest.)
_____ Are sterilization procedures in concert with required and accepted techniques?
(Autoclaving, acceptable sterilizing solutions, ultrasonic debriding etc.)

4. Neatness *as if you were the patient*
_____ Are objects such as children's toys, magazines, pillows, etc. being left lying around?
_____ Are mirrors and pictures hanging straight?
_____ Are desk tops uncluttered?
_____ Are shelves uncluttered?
_____ Are supplies being placed away rather than being left on the floor or counter tops?

5. Patient Accessibility *as if you were the patient*
_____ Have adequate parking provisions been made for patients?
_____ Are there special handicapped parking places?
_____ Are there ramps for wheelchairs?
_____ Are hallways and doorways wide enough for wheelchairs?

6. Musical System *as if you were the patient*
_____ Is there a music system throughout the office?
_____ Are there different radios playing at the same time?
(Explanation: Music of a different nature from different sources is disconcerting and should be eliminated.)
_____ Is the music too loud?
(Explanation: Music that drowns out normal conversation or prevents task completion should be toned down.)
_____ Is the radio program selection appropriate?
(Explanation: Loud music is not appropriate for a professional office and neither is hard rock or jazz. Music should be passive and soothing.)
_____ Is a personal headset used for each patient? Should there be?

(Explanation: a calculator with a PRINT OUT is very helpful in reducing mathematical errors.)

12. Professional Literature *as if you were the patient*
_____ Is there professional literature displayed in the reception area?
_____ Is Literature easily read and appropriate? Suggestions?
_____ Is the literature neatly displayed as with a rack:
_____ Is the rack out of the reach of small children?
(Explanation: Small children generally collect these pamphlets and dispose of them or leave them throughout the reception area. This creates extra work for the receptionist and is also costly.)
_____ Is the rack overcrowded or overstocked?
(Explanation: There should only be the required number of pamphlets to explain dental procedures without getting repetitious. Saying the same thing over and over is unnecessary. Patients are best served by having a "few well-chosen informative pamphlets.)

13. Doctor and Staff Appearance *as if you were the patient*
_____ Are all office members wearing uniforms?
(Explanation: Our posture is that all office members should wear uniforms.)
_____ Is there a continuity of uniforms?
(Explanation: All staff members should have the same uniform. White is not required but uniformity of color is required. The doctor is permitted to wear a different uniform.)
_____ Are uniforms neat, clean, fitted properly?
(Explanation: This means not too tight, properly buttoned or zippered, unwrinkled, untorn.)
Check for:
_____ Perfume scents that are too strong.
_____ Smoking scents.
_____ Bad breath.
_____ Improperly groomed.
(Explanation: Unshaven-this does NOT mean beards or mustaches; it refers to generally untidy appearance.)

_____ Unkempt finger nails.
_____ Too much makeup.
_____ Too much jewelry.
_____ Is proper English being used?
Check for untidy habits:
_____ Licking fingers
_____ Biting nails
_____ Not washing hands
_____ Toothpicks
_____ Chewing on pencils
_____ Are any staff members making a poor appearances?
_____ Is food, coffee, sweets, chewing gum or any other edible product being used in front of patients?
(Explanation: Food is not to be displayed in front of patients-especially sweets.)
_____ Are staff members or doctors smoking in front of patients? (Explanation: This is not to be allowed.)

15. Non-health Items *as if you were the patient*
_____ Are non-health items being distributed to patients?
(Explanation: Sweets should not be given to children as a reward. This includes ice cream cone prescriptions.)

16. Favors *as if you were the patient*
_____ Are favors being given to patients?
(Explanation: Favors are recommended very strongly. Toothbrush kits, especially after a prophylaxis, as well as toys for children and variety items for adults are highly recommended. Stickers for the telephone for numbers to be written in and which have the dentist's number are a strong strategy.)

17. Answering Service *as if you were the patient*
_____ Is there an answering service?
(Explanation: There should be an answering service. It can be in the form of an operator controlled service or simply an answering machine.)
_____ Is the service being operated properly.
(Explanation: Call the answering service. If operator controlled, observe if the answer is prompt, polite, and informative. If an answering machine, listen to the message and ensure that it is not hurried, is clear and sounds warm and asks for a response.)

18. Staff Identification *as if you were the patient*
_____ Are staff members wearing name tags with titles?
_____ Do staff members have their own professional cards?
(Explanation: Giving staff members tags and cards imparts recognition which is important to convey the sense of the team concept.)

20. Prevention Program *as if you were the patient*
_____ Are prevention instructions being provided?
(Explanation: Prevention instructions should be provided to all patients. In addition, each patient should receive a list of preventive aids that are to be obtained.)

21. Adherence to Schedule *as if you were the patient*
_____ Are patients being taken on time?
(Explanation: The appointment book should be checked as each patient enters the operatory to ensure that patients are being seen on time. In addition, it should be noted if patients are becoming restless or irritated from waiting.)

22. Office Communications *as if you were the patient*
_____ Are patients being acknowledged immediately upon approaching the reception desk?
_____ Is the telephone being answered within 3 rings?
_____ Are patients being asked to "hold" for unreasonable periods of time?
_____ Is the telephone being answered in a courteous manner?
(Explanation: Good morning, afternoon, evening, Dr. _____'s office, name of receptionist speaking, may I help you please?)
_____ Are new patients being asked for their name, address and telephone numbers?
_____ Is the caller being thanked for calling?
_____ Is there too much chatter at the front deck?
_____ Are staff members congregating around the front desk?
_____ Are patients being asked politely to have a seat and that the doctor will be with them shortly?
_____ Are patients being accompanied t the operatory?
_____ Is the chair being adjusted into a comfortable position for the patient?
_____ Is the patient being asked if he/she is comfortable?
_____ Does the assistant ensure that the light is not shining in the patient's eyes?

_____ Is the patient being given a magazine?
_____ Are there at least 2 incoming lines into the office?
_____ Are there push button phones?
_____ Does the receptionist have a headset? (Explanation: This is a matter of preference.)
_____ Is there a message pad and pen near the telephone?
_____ Are there chimes instead of harsh bells on the telephones?
(Explanation: Chimes are a lot less grating on the nerves.)
_____ Is there an intercom system?
_____ Is there a healthy flow of information from the doctor to the receptionist so that the receptionist is aware of the patient's appointment needs?

32. Other areas that need to be addressed.

35. If this were your practice what would you want to do and how would you do it. (essay)

Staff Questionnaire

1. What do you like most about our office ? ----------

   ---

2. What do you dislike about our office ? ----------

   ---

3. How would you evaluate our dental services? ----------

   ---

4. How would evaluate our staff ? ----------

   ---

5. Is there anyone on our staff who stands out most in your mind . Good____ Bad_____Why ? ____

   ---

6. If this was your dental practice what one thing would you do to improve the quality of care?

   ---

7. What one thing would you do to improve production ?

   ---

8. What other suggestions do you have to make our office a better place to work?

Employee Medical Insurance Update Choice Form

Dear Team Members,

It is time to renew our medical insurance for the period 4/1/2012 to 3/31/2013. As a benefit to our employees, Dental Health Associates will continue to offer medical insurance through BC/BS. We are also happy to continue the triple option in our health care benefit. This year we received an unprecedented increase in our health Care Premiums. To keep our medical benefits viable, we have selected to share the increase with all out participating employees.

In order to continue your medical benefits, and/or to select an upgrade from our base plan, please review the following options and select by initialing the option(s) you want. This form must be returned to me by March 15th, 2012 so we can establish a payroll deduction schedule and ensure there is no lapse of coverage.

Please remember that due to the new Federal Health law, all of the "healthy" visits or yearly checkups have NO copayments.

Blue Choice In-Network:
Employee contributes with $12 per pay period ($177 for individual & children) per pay period
$30/$40 copay per admission
$100 copay ER
Includes VISION
fees.
Has out of network benefit: 80% coinsurance
DRUG COVERAGE: $250 deductible a year
Non maintenance: $15 gen, $25 brand-formulary, $50 brand non formulary 34 day supply
Maintenance: $30 gen, $50 brand-formulary, $100 brand non formulary 90 day supply

_____
Employee initial indicates selection of this plan option and associated

UPGRADE:
Blue Choice Opt Out Plus OA, Option 6
Employee contributes with $65.00 ($259 for individual & children) per pay period
$20/$30 copay per admission
$35 copay ER
Includes VISION
Has out of network benefit: 80% coinsurance
DRUG COVERAGE: $100 deductible a year
Non maintenance: $15 gen, $25 brand-formulary, $50 brand non formulary 34 day supply
Maintenance: $30 gen, $50 brand-formulary, $100 brand non formulary 90 day supply

_____
Employee initial indicates selection of this plan option and associated fees.

Blue Choice Opt Out OA, Option 1
Employee contributes with $94 ($324 for individual & children) per pay period
$10/$20 copay per admission
$35 copay ER
Includes VISION
Has out of network benefit: 80% coinsurance
DRUG COVERAGE: $0 deductible a year
Non maintenance: $15 gen, $25 brand-formulary, $50 brand non formulary 34 day supply
Maintenance: $30 gen, $50 brand-formulary, $100 brand non formulary 90 day supply

_____
Employee initial indicates selection of this plan option and associated fees.

I have selected NOT to participate.
with Medical Benefits listed above _____ *Employee initial indicates selection of this plan option and associated fees.*

Thank you;
Employee Name _____

Dr. Centty Employee Signature _____

Appendix 1.4: Charts

Patient Name ________________________________ Medical Alert ____

Date Done	Tooth #	Diagnosis / Problem	Treatment Recommended	Accepted / Rejected Comments	Date Presented	Sign.

Patient Name ________________________________ Medical Alert ____

	Date	Date
Change in medical history		
Head-Neck Examination		
Extra Oral (skin/neck/nodes)		
Peri Oral (lips)		

Patient Name ____________________________________ Medical Alert ____

Date	Tooth #		Treatment Notes			Sign.

Appendix 2: Outgoing Forms, Letters, and Instructions

Appendix 2.1: Forms

‘All on Implants’ Consent Form

Patient _____

I acknowledge that Dr. _____ has explained to me the foreseeable risks and consequences associated specifically with the ‘ All on Implants ‘ procedure(s) as well as the reasonable benefits that may be expected from therapy.

In addition, the dentist listed above has explained to me the reasonable alternatives, if any, to the proposed treatment (that include no treatment) and their risks. I fully understand the risks and complications and alternative procedures that I am going to receive and have been provided with adequate time and information to ask questions receive reasonable answers. I have been given the opportunity to receive second opinion consultations from other dentists and specialist.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made concerning the results of this procedure. Complications of therapy can include, but are not limited to the following: pain or discomfort of the jaws, face, head, neck, sinuses, muscles, chip or fracture of the temporary or permanent prosthesis, replacement of the prosthesis or implant at some point in time, loss of prosthesis or implant, loss of residual teeth, or permanent disfiguration.

Success of treatment is heavily dependent upon the healing capacity of my body in which is out of the doctors control, following all of the doctors recommendations to their fullest implied extent and effective oral hygiene performed by myself as well as regular professional maintenance (cleaning), in my case every 3 to 4 months.

I have been informed of the estimated financial cost of treatment and I am aware that the final cost of treatment may change without notice due to application restrictions, denials, or changes in dental benefits or other unforeseen complications. I accept that ultimately I am responsible for all balances regardless of cause on or after 90 days from the date of treatment.

I accept that should I delay or refuse to continue treatment I progress for any cause I will be responsible for all treatment provided and I am allowed reimbursement for prepaid items less any incurred cost for such procedures.

I certify that I have read the above and that I understand its contents and consent to the above explained treatment.

Patient Signature _____ Date _____

Pre-Treatment Consent – Periodontal Treatment '07

Patient Name _____ Attending Dentist _____

_____ I understand and accept that I have periodontal disease and my treatment plan is

I understand that this disease involves the soft tissues surrounding my teeth (gum tissue), those tissues which attach the teeth to the bone, and the bone itself. I further understand that causes of periodontal disease are complex and may include a genetic factor, hard and soft deposits on the teeth (plaque, calculus) and various bacteria and their toxins.

I understand that there may be symptoms such as bleeding of the gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth (mobility, drifting) and possible loss of teeth. I also realize that this disease may be painless and symptom less.

It has been explained and I understand that treatment of periodontal disease involves the removal of all debris; the removal of diseased tissue surrounding the teeth, including diseased cementum (the outer covering of the root surface) and bacterial calculus, plaque and toxins; possible surgical removal (or re-contouring) of excess tissue (bone, teeth, gums) and monitoring of home care to maintain tissue health.

It has been explained and I understand my own home care efforts are just as important as my professional treatment. Failure to follow proper home care may also complicate treatment or result in a less effective result. I understand that additional referrals may still be necessary and that there are no guarantees involved in this treatment; I understand that I may still experience tooth sensitivity to hot and cold, loose teeth and/or possible loss of teeth in the future.

_____ I understand and accept that allowing this disease to remain may result in infection and/or cyst formation that may irreversibly destroy bone; damage the roots of the adjacent teeth and/or create a food trap that may result in decay pain, swelling or tooth loss

_____ I understand and accept the treatment recommended for me by my attending dentist. The benefits and risks periodontal treatment have been explained to me that includes alternative treatment(s), referral or the option of no treatment and are summarized below

_____ I understand and accept Treatment risks/unwanted consequences may be (but are not limited to):
Damage to adjacent teeth or restorations
Tooth/root may be deemed non restorable and a extraction may be necessary
Reaction to medications/anesthetic
Post-treatment tissue swelling, bruising, bleeding, Sensitivity, pain or infection
Healing may be delayed and require additional treatment
Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
Increased tooth mobility, sensitivity/pain to hot, cold, or sweets, which may resolve, require further treatment, or may persist, no matter what is done
Need for additional tooth cleaning/periodontal care or treatments, technique(s) or appliances
Additional consultations and treatment that will incur additional fees not yet discussed

_____ I understand and accept no aesthetic/functional guarantees have been made or implied. I understand that there maybe an unwanted esthetic results (disagreement involving appearance) such as exposed root surface due to recession of the gum line and exposure of the crown margins or decreased function of other teeth or dental appliances. These unwanted issues might require additional treatment.

_____ I understand and accept no outcome guarantees have been made or implied. I understand that risk of failure; relapse or worsening of my condition may result regardless of the efforts made during treatment. Additional treatment is always a possibility, or may be required with an additional fee.

_____ I understand and accept fiduciary responsibility for all treatment rendered, to include any additional treatment that may become necessary for optimum results. The proposed treatment and estimated fees have been explained to me, or have been made available upon my request, as have any third party benefits. I understand that third party benefits may be different than discussed, as they are not under the control of this office.

With my signature below, I acknowledge all of my questions have been answered. I have been offered a copy of this consent for my records. I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms I will contact Dental Health Associates at (301) 439-7878 for a phone consultation or follow-up visit. I also acknowledge that should the office be closed that I will contact the after-hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient/Guardian Signature_____ Date _____

Informed Consent for At-Home Mouthguard Bleaching

Below are several considerations related to using carbamide peroxide solution for the purpose of whitening teeth. Please read carefully.

1. The active ingredient is carbamide peroxide in a glycerin base. If you are aware of any allergy or adverse reaction to this ingredient, do not proceed with treatment.
2. Peroxide solutions have been available for many years as an antiseptic in the mouth. It has only recently been more widely used for its effects on teeth. The FDA has approved its use as an antiseptic but has not acted on its use as a treatment for whitening teeth.
3. As with any treatment, there are benefits and risks. The benefit is that teeth of many patients can be whitened in a fairly quick and simple manner. The risk involves the constant use of the peroxide solution for an extended period. Research indicates that using peroxide on teeth is safe. There is no definite research, however, indicating the safety for the soft tissue (gingival, cheek, tongue, throat). Although preliminary findings are encouraging, long-term effects are not known. Although extent of risk is unknown, acceptance of treatment means acceptance of risk.
4. The amount of whitening varies with the individual. The average patient achieves considerable change within 2-7 weeks of use. Coffee, tea, and tobacco will stain teeth after treatment in the same manner as before treatment.
5. You may experience sensitivity (usually slight and temporary) which will subside when treatment is discontinued.
6. While there have been no adverse reactions of exposure to one or two vials of NiteWhite, we recommend that heavy smokers and pregnant women obtain permission from their physician prior to beginning the procedure.

I have read the above information. I agree to return for examination in __ days after treatment begins and at any recommended time afterwards. I have read and received a copy of the instruction/information sheet. I understand the directions and information and had the opportunity to ask questions. I hereby consent to treatment, and I assume the risks described above.

Patient Name and Signature _____

Dentist or Hygienist _____ Date _____

NiteWhite Informed Consent

Dentist: _____

Patient: _____

Address: _____

Phone: _____

Home "teeth bleaching techniques" are designed to lighten dark or stained teeth. Patients apply an oxygenating or peroxide type material at home using one of several techniques. While these materials appear to be safe, because their use is new (1989), unexpected problems can occur. Tooth sensitivity or tingling is the most common side effect. Soft tissue irritation can also occur. If a patient experiences these or other adverse symptoms, he/she should stop using the bleaching material, and consult his/her treating dentist.

Patients should also understand that the amount of bleaching and its duration may vary. While most teeth lighten to the extent desired, some do not. In some instances lightening is minimal or unapparent. In all instances, additional bleaching over time may be required to maintain the lighting originally obtained.

I have read and understand the above description of possible consequences of using home bleaching techniques. Being fully informed, I consent to and agree to use these techniques.

_____ _____

I consent to photographs being taken. I understand they may be used for documentation and for illustration of my treatment.

_____ _____

Consent for Treatment (Child)

I am the (parent or guardian) of _____ (name of child) who is a minor, and I authorize examination and treatment as necessary by, or under the supervision of,
Dr. _____. This includes exposure of radiographs as necessary, use of a local anesthetic, reasonable restraint as needed, and use of appropriate medicaments and materials for such treatment.

Patient Signature _____ Date _____

Witness _____

General Therapy Consent Form

Patient _____

I acknowledge that Dr. _____ has explained to me the foreseeable risks and consequences associated specifically with the procedure(s) described as well as the reasonable benefits which may be expected from therapy. In addition, Dr. _____ _____ has explained to me the reasonable alternatives, if any, to the proposed treatment and their risks. I fully understand the risks and complications and alternative procedures that I am going to receive.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made concerning the results of this procedure. Complications of therapy can include, but are not limited to the following: discomfort, temperature sensitivity, the need of root canal therapy, the chip or fracture of the temporary or permanent prosthesis, replacement of the prosthesis at some point in time, loss of prosthesis, loss of teeth, permanent disfiguration.

Success of treatment is heavily dependent upon effective oral hygiene performed by myself as well as regular professional maintenance (cleaning), in my case every 3 to 4 months.

I have been informed of the estimated financial cost of treatment and I am aware that the final cost of treatment may change without notice due to application restrictions, denials, or changes in dental benefits or other unforeseen complications. I accept that ultimately I am responsible for all balances regardless of cause on or after 90 days from the date of treatment.

I accept that should I delay or refuse to continue treatment I progress for any cause I will be responsible for all treatment provided and I am allowed reimbursement for prepaid items less any incurred cost for such procedures.

I certify that I have read the above and that I understand its contents and consent to the above explained treatment.

Patient Signature _____ Date _____

Witness _____

Consent for Periodontal/Implant Treatment

_____
Patient Name

I hereby authorize (Doctor's Name) to render periodontal surgical therapy. (Doctor's Name) has explained the method and manner of the proposed periodontal treatment and the desirability of such surgical treatment to slow or arrest the progression of the periodontal disease or repair existing damages or defects. Although periodontal/implant therapy has a high degree of clinical success, it is still a biological procedure and final results may vary.

I am aware that the practice of anesthesia, medicine, and surgery is not an exact science and I acknowledge that no guarantees have been made concerning the results of the procedure. Success of periodontal/implant treatment is heavily dependent upon effective oral hygiene performed by myself as well as regular periodontal maintenance (cleaning), and following all instructions as prescribed by all oral health providers.

Complications of periodontal/implant therapy can include, but are not limited to, the following: discomfort, swelling, infection, bleeding, limited jaw opening, involvement of the sinuses, extended length of the teeth, temperature sensitivity, enlarged spaces between teeth, tooth mobility, tooth loss, the need for root canal therapy, and numbness of the teeth, lip, tongue, and gums, which, if present, can be temporary or permanent in duration.

I understand that those medicines used to control pain and/or provide sedation may cause drowsiness which may be increased by the use of alcohol or other drugs. I have been advised of the potential side effects and the necessary precautions of such medications.

I certify that I have read the above and that I understand its contents and consent to the above explained treatment. I further acknowledge that (Doctor's Name) has explained to me the foreseeable risks and consequences associated specifically with the procedure(s) described as well as the reasonable benefits that may be expected from the therapy. In addition, (Doctor's Name) has explained to me the reasonable alternatives, if any, to the proposed treatment and their risks.

(Doctor's Name) has provided me with adequate time to evaluate my treatment options and the opportunity to ask any, and all, questions regarding my treatment. I have received satisfactory and complete answers to the questions and have decided to proceed with treatment.

My treatment plan is:

___ Osseous Surgery

___ Guided Tissue Regeneration

___ Implant Body Placement

___ Surgical Extraction

Patient Signature _____ Date _____

Pre-Treatment Consent for Tooth Removal (Extractions)

Patient Name _____ Attending Dentist _____

The benefits and risks of tooth removal have been explained to me. I understand that surgical extraction may be necessary. Referral to an oral surgeon has been offered. I understand that risk of failure, relapse or worsening of my condition may result regardless of the efforts made during treatment. Additionally, re-treatment is always a possibility, or may be required with an additional fee.

_____ **I understand and accept the treatment recommended for me by my attending dentist.** No guarantees have been made or implied. I understand that allowing this tooth/teeth to remain may result in infection and/or cyst formation which may destroy bone; damage the roots of the adjacent teeth from pressure of the malposed tooth/teeth; and/or create a food trap which may result in decay. Alternative treatment(s) or the option of no treatment has been explained to me.

_____ **I decline the above option and elect to proceed with a compromised treatment plan.** I understand the risk of not having the extraction(s) performed; whether the tooth/teeth are impacted, partially impacted, or not impacted at all, include, but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, and systemic disease.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Post-treatment tissue swelling, bruising, bleeding, or infection
- Root fragments may break; they may bleed, become infected, or be left in the jaw
- Sinus involvement when upper teeth are removed, which may require additional treatment
- Jaw or alveolar bone may fracture during tooth removal, which may require additional treatment
- Healing may be delayed and require additional treatment (such as for a dry socket)
- Sensitivity, pain
- Damage to adjacent teeth or restorations

I accept the fiduciary responsibility for all treatment rendered, to include any additional treatment that may become necessary for optimum results. The proposed treatment and estimated fees have been explained to me, or have been made available upon my request, as have any third party benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office.

I have been offered a copy of this consent for my records. All of my questions have been answered and I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or follow-up visit. I also acknowledge that should the office be closed that I will contact the after-hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient Signature_____ Date _____

Witness _____

Pre-Treatment Consent for Prosthodontic Treatment

Patient Name _____ Attending Dentist _____

The benefits and risks of dental prosthetic treatment have been explained to me. Referral to a specialist for treatment, consultation, or a second opinion has been offered. Dental prosthetic appliances may be fixed or removable. They are designed to replace missing teeth and will not chew as efficiently as natural teeth and may acquire stains, odor, and retain food in spots.. They are made of a variety of materials and various alternatives have been explained to me including the benefits of each available alternative. They are retained in the mouth by a variety of methods. The specific designs for the appliance (including possible alternatives) have been explained to me.

Fixed dental prosthetics, if proposed, including crowns (covering the entire tooth), bridges, inlays, onlays, and laminates have been explained including the proposed materials to be used and available alternatives. Removable appliances, if proposed, have been explained to me, including the materials involved. I understand removable dentures will require relines in time due to changes in the gum tissue and the underlying bone.

Treatment risks/unwanted consequences of the proposed prosthodontic treatment may be (but are not limited to): reaction to medications/anesthetic; numbness induced from pressure of a removable denture requiring adjustment or other procedure; potential for root canal treatment/home care responsibilities; breakage of appliance/porcelain fracture; recurrent decay; wear of teeth which oppose the prosthesis (opposite jaw); changes in speech; temporamandibular joint dysfunction due to changes in the bite, which may require additional treatment; stability/movement of appliances (including retention of removable appliances); damage to adjacent teeth or restorations. Alternative treatment option(s) and the option of no treatment have been explained to me.

My treatment plan includes _____

I understand and accept the treatment recommended for me by my attending dentist. No guarantees have been made or implied.

I decline the above option and elect to proceed with a compromised treatment plan. I understand that the risks of not having treatment may include, but are not limited to, problems with the bite and periodontal disease related to teeth that have changed position and/or are under stress. I also understand that I will be provided hygiene visits to review treatment options and if I decline again, I will select another dental office for all additional care.

I accept the fiduciary responsibility of all treatment rendered, including any additional treatment that may become necessary for optimal results. The proposed treatment and estimated fees have been explained to me, or have been made available on my request, as have any third party benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office. I accept the fiduciary responsibility of all treatment rendered.

I have been offered a copy of this consent for my records. I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or a follow-up visit. I also acknowledge that should the office be closed, I will contact the after-hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient Signature _____ Date _____

Witness _____ Dentist _____

Pre-Treatment Consent for Periodontal Treatment

Patient Name _____ Attending Dentist _____

The benefits and risks of periodontal treatment for have been explained to me. I understand that periodontal disease involves the soft tissues surrounding my teeth (gum tissue), those tissues which attach the teeth to the bone, and the bone itself. I further understand that causes of periodontal disease are complex and may include a genetic factor, hard and soft deposits on the teeth (plaque, calculus) and various bacteria and their toxins. I realize that there may be symptoms such as bleeding of the gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth (mobility, drifting) and possible loss of teeth. I also realize that this disease may be painless and symptomless.

I also understand that a risk of failure, relapse or worsening of my periodontal condition may result regardless of the efforts made during treatment. Additionally, re-treatment, or additional treatment is always a possibility, or may be required with an additional fee.

It has been explained to me that treatment of periodontal disease involves the removal of all debris; the removal of diseased tissue surrounding the teeth, including diseased cementum (the outer covering of the root surface) and bacterial calculus, plaque and toxins; possible surgical removal (or re-contouring) of excess tissue (bone, teeth, gums) and monitoring of home care to maintain tissue health. Additionally, it has been explained to me that my own home care efforts are just as important as my professional treatment. Failure to follow proper home care may also complicate treatment or result in a less effective result. I understand that additional referrals may still be necessary and that there are no guarantees involved in this treatment. I understand that I may still experience tooth sensitivity to hot and cold, loose teeth and/or possible loss of teeth in the future.

_____ **I understand and accept the treatment recommended for me by my attending dentist.** No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me.

_____ **I decline the above option and elect to proceed with a compromised treatment plan.** I understand the consequences of my decision not to have treatment may include, but are not limited to: the loss of gum and bone tissue, loosening of teeth, and loss of teeth as a cleaning by itself might not prevent the advancement of the disease or correct the disease. I also understand that I will be provided other hygiene visits to review treatment options and if I decline again I will select another dental office for all additional care.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic
- Post-treatment tissue swelling, bruising, bleeding, or infection
- Increased sensitivity to hot, cold, or sweets, which may require further treatment, may resolve, or may persist, no matter what is done
- Poor aesthetic result (disagreement involving appearance)
- Exposure of the crown margins
- More exposed root surface due to recession of the gum line
- Pain in the associated teeth, including roots
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Need for proper cleaning technique(s) as explained to remove food between teeth
- Tooth mobility/loss
- Additional consultations and treatment that will incur additional fees not yet discussed

I accept the fiduciary responsibility for all treatment rendered, to include any additional treatment that may become necessary for optimum results. The proposed treatment and estimated fees have been explained to me, or have been made available upon my request, as have any third party benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office.

I have been offered a copy of this consent for my records. All of my questions have been answered and I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or a follow-up visit. I also acknowledge that should the office be closed, I will contact the after-hours attending dentists with the phone number on the Dental Health Associates voice mail.

Patient Signature _____ Date _____

Witness _____

Pre-Treatment Consent for Surgical Periodontal Treatment

Patient Name _____ Attending Dentist _____

It has been explained to me that I have periodontal disease and treatment options have been recommended. I understand that this disease involves the soft tissues surrounding my teeth (gum tissue), those tissues which attach the teeth to the bone, and the bone itself. I further understand that causes of periodontal disease are complex and may include a genetic factor, hard and soft deposits on the teeth (plaque, calculus) and various bacteria and their toxins. I realize that there may be symptoms such as bleeding of the gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth (mobility, drifting) and possible loss of teeth. I also realize that this disease may be painless and symptomless.

It has been explained to me that treatment of periodontal disease involves the removal of all debris; the removal of diseased tissue surrounding the teeth, including diseased cementum (the outer covering of the root surface) and bacterial calculus, plaque and toxins; possible surgical removal (or re-contouring) of excess tissue (bone, teeth, gums) and monitoring of home care to maintain tissue health.

It has been explained to me that my own home care efforts are just as important as my professional treatment. Failure to follow proper home care may also complicate treatment or result in a less effective result. I understand that additional referrals may still be necessary and that there are no guarantees involved in this treatment; I understand that I may still experience tooth sensitivity to hot and cold, loose teeth and/or possible loss of teeth in the future.

My treatment plan includes _____

_____ **I understand and accept the treatment recommended for me by my attending dentist**. No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I understand that the risks of not having treatment may include, but are not limited to, problems with the bite and periodontal disease related to teeth that have changed position and/or are under stress. All of my questions have been addressed and I further understand that there may be some unwanted complications, some of which are listed below.

_____ **I decline the above option and elect to proceed with a compromised treatment plan**. I understand that a consequence of this decision may be the loss of gum and bone tissue, loosening of teeth, and loss of teeth as a cleaning itself might not prevent the advancement of the disease or correct the disease. I also understand that I will be provided other hygiene visits to review treatment options and if decline again, I will select another dental office for all additional care.

I also understand that a risk of failure, relapse or worsening of my periodontal condition may result regardless of the efforts made during treatment. Additionally, re-treatment, or additional treatment is always a possibility, or may be required with an additional fee. No guarantees have been made or implied toward outcomes or results and there may be some unwanted complications, some of which are listed below.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic
- Post-treatment tissue swelling, bruising, bleeding, or infection
- Increased sensitivity to hot, cold, or sweets, which may require further treatment, may resolve, or may persist, no matter what is done
- Poor aesthetic result (disagreement involving appearance)
- Exposure of the crown margins
- More exposed root surface due to recession of the gum line
- Pain in the associated teeth, including roots
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Need for proper cleaning technique(s) as explained to remove food between teeth
- Tooth mobility/loss
- Additional consultations and treatment that will incur additional fees not yet discussed

The proposed treatment and estimated fees have been explained to me, or have been made available on my request, as have any third party insurance benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office. I accept the fiduciary responsibility of all treatment rendered.

I have been offered a copy of this consent for my records. I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or a follow-up visit. I also acknowledge that should the office be closed, I will contact the after-hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient Signature _____ Date _____

Witness _____ Dentist _____

Pre-Treatment Consent for Non-Surgical Periodontal Treatment

Patient Name _____ Attending Dentist _____

Dr. _____ has explained to me that I have periodontal disease and has recommended treatment options to me. I understand that this disease involves the soft tissues surrounding my teeth (gum tissue), those tissues which attach the teeth to the bone, and the bone itself. I further understand that causes of periodontal disease are complex and may include a genetic factor, hard and soft deposits on the teeth (plaque, calculus) and various bacteria and their toxins. I realize that there may be symptoms such as bleeding of the gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth (mobility, drifting) and possible loss of teeth. I also realize that this disease may be painless and symptomless.

It has been explained to me that treatment of periodontal disease involves the removal of all debris; the removal of diseased tissue surrounding the teeth, including diseased cementum (the outer covering of the root surface) and bacterial calculus, plaque and toxins; possible surgical removal (or re-contouring) of excess tissue (bone, teeth, gums) and monitoring of home care to maintain tissue health.

It has been explained to me that my own home care efforts are just as important as my professional treatment. Failure to follow proper home care may also complicate treatment or result in a less effective result. I understand that additional referrals may still be necessary and that there are no guarantees involved in this treatment; I understand that I may still experience tooth sensitivity to hot and cold, loose teeth and/or possible loss of teeth in the future.

My treatment plan includes _____

_____ **I understand and accept the treatment recommended for me by my attending dentist**. No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I understand that the risks of not having treatment may include, but are not limited to, problems with the bite and periodontal disease related to teeth that have changed position and/or are under stress. All of my questions have been addressed and I further understand that there may be some unwanted complications, some of which are listed below.

_____ **I decline the above option and elect to proceed with a compromised treatment plan**. I understand that a consequence of this decision may be the loss of gum and bone tissue, loosening of teeth, and loss of teeth as a cleaning itself might not prevent the advancement of the disease or correct the disease. I also understand that I will be provided other hygiene visits to review treatment options and if decline again, I will select another dental office for all additional care.

I also understand that a risk of failure, relapse or worsening of my periodontal condition may result regardless of the efforts made during treatment. Additionally, re-treatment, or additional treatment is always a possibility, or may be required with an additional fee. No guarantees have been made or implied toward outcomes or results and there may be some unwanted complications, some of which are listed below.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic
- Post-treatment tissue swelling, bruising, bleeding, or infection
- Increased sensitivity to hot, cold, or sweets, which may require further treatment, may resolve, or may persist, no matter what is done
- Poor aesthetic result (disagreement involving appearance)
- Exposure of the crown margins
- More exposed root surface due to recession of the gum line
- Pain in the associated teeth, including roots
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Need for proper cleaning technique(s) as explained to remove food between teeth
- Tooth mobility/loss
- Additional consultations and treatment that will incur additional fees not yet discussed

The proposed treatment and estimated fees have been explained to me, or have been made available on my request, as have any third party insurance benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office. I accept the fiduciary responsibility of all treatment rendered.

I have been offered a copy of this consent for my records. I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or a follow-up visit. I also acknowledge that should the office be closed, I will contact the after-hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient Signature _____ Date _____

Witness _____ Dentist _____

Pre-Treatment Consent for Other Surgical Treatment

Patient Name _____ Attending Dentist _____

It has been explained to me that I have periodontal disease and treatment options have been recommended for me. I understand that this disease involves the soft tissues surrounding my teeth (gum tissue), those tissues which attach the teeth to the bone, and the bone itself. I further understand that causes of periodontal disease are complex and may include a genetic factor, hard and soft deposits on the teeth (plaque, calculus) and various bacteria and their toxins. I realize that there may be symptoms such as bleeding of the gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth (mobility, drifting) and possible loss of teeth. I also realize that this disease may be painless and symptomless.

It has been explained to me that treatment of periodontal disease involves the removal of all debris; the removal of diseased tissue surrounding the teeth, including diseased cementum (the outer covering of the root surface) and bacterial calculus, plaque and toxins; possible surgical removal (or re-contouring) of excess tissue (bone, teeth, gums) and monitoring of home care to maintain tissue health.

It has been explained to me that my own home care efforts are just as important as my professional treatment. Failure to follow proper home care may also complicate treatment or result in a less effective result. I understand that additional referrals may still be necessary and that there are no guarantees involved in this treatment; I understand that I may still experience tooth sensitivity to hot and cold, loose teeth and/or possible loss of teeth in the future.

My treatment plan includes _____

_____ **I understand and accept the treatment recommended for me by my attending dentist**. No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I understand that the risks of not having treatment may include, but are not limited to, problems with the bite and periodontal disease related to teeth that have changed position and/or are under stress. All of my questions have been addressed and I further understand that there may be some unwanted complications, some of which are listed below.

_____ **I decline the above option and elect to proceed with a compromised treatment plan**. I understand that a consequence of this decision may be the loss of gum and bone tissue, loosening of teeth, and loss of teeth as a cleaning itself might not prevent the advancement of the disease or correct the disease. I also understand that I will be provided other hygiene visits to review treatment options and if decline again, I will select another dental office for all additional care.

I also understand that a risk of failure, relapse or worsening of my periodontal condition may result regardless of the efforts made during treatment. Additionally, re-treatment, or additional treatment is always a possibility, or may be required with an additional fee. No guarantees have been made or implied toward outcomes or results and there may be some unwanted complications, some of which are listed below.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic
- Post-treatment tissue swelling, bruising, bleeding, or infection
- Increased sensitivity to hot, cold, or sweets, which may require further treatment, may resolve, or may persist, no matter what is done
- Poor aesthetic result (disagreement involving appearance)
- Exposure of the crown margins
- More exposed root surface due to recession of the gum line
- Pain in the associated teeth, including roots
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Need for proper cleaning technique(s) as explained to remove food between teeth
- Tooth mobility/loss
- Additional consultations and treatment that will incur additional fees not yet discussed

The proposed treatment and estimated fees have been explained to me, or have been made available on my request, as have any third party insurance benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office. I accept the fiduciary responsibility of all treatment rendered.

I have been offered a copy of this consent for my records. I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or a follow-up visit. I also acknowledge that should the office be closed, I will contact the after-hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient Signature _____ Date _____

Witness _____ Dentist _____

Pre-Treatment Consent for Endodontic Treatment

Patient Name _____ Attending Dentist _____

The benefits and risks of endodontic treatment have been explained to me. Referral to a specialist (endodontist) for treatment or consultation for a second opinion has been offered. I understand that endodontic treatment involves the removal of tissues in the center of the tooth (root canal) and the sealing of the space that is created during the process of removal and cleansing of the root canal system. I understand that the root canal treatment may fail if proper restoration of the tooth is not completed after root canal is done, and that such restoration is a separate and distinct procedure with an additional fee. I further understand that this treatment may fail regardless of the efforts made during treatment and re-treatment or additional treatment is always a possibility or may be required with an additional charge.

_____ **I understand and accept the treatment recommended for me by my attending dentist**. No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I understand that an alternative treatment may include extraction of the involved tooth or teeth.

_____ **I decline the above option and elect to proceed with a compromised treatment plan**. I understand the consequences of my decision not to have treatment may include, but are not limited to: infection; swelling; cyst formation; pain; loss of tooth/teeth; and/or systemic disease. I also understand that I will be provided other hygiene visits to review treatment options and if I decline again, I will select another dental office for all additional care.

Treatment risks/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic/antibiotics
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Potential for re-treatment of root canal or possible surgical treatment
- Residual bone infection, which may require surgical treatment
- Instrument breakage in the tooth/perforation of the root(s)
- Recurrent decay
- Tooth color may change (become darker than adjacent teeth)
- Post-treatment swelling, bruising, pain, or infection
- Root fracture/crown fracture
- Tooth loss
- Additional consultation and treatments that will incur additional fees not yet discussed

I accept the fiduciary responsibility for all treatment rendered, to include any additional treatment that may become necessary for optimum results. The proposed treatment and estimated fees have been explained to me, or have been made available upon my request, as have any third party benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office.

I have been offered a copy of this consent for my records. All of my questions have been answered and I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or a follow-up visit. I also acknowledge that should the office be closed, I will contact the after hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient _____ Date _____

Witness _____ Dentist _____

Pre-Treatment Consent for Implant Treatment

Patient Name _____ Attending Dentist _____

The benefits and risks of dental implants have been explained to me. Additional referral for consultations for this treatment has been offered. I understand that implants are placed into the bone. I further understand that implant treatment is complex and includes the need for proper prosthetic restoration. I also understand that the placement of the implant device and associated risks are separate from the restoration of the implant.

I understand the number and location of implant devices will depend on the availability of adequate bone to support the implant and the number of teeth that need to be replaced. I accept that if during the procedure it is determined that additional procedures be provided to increase the chances of optimal implant integration that may include additional implants, bone grafting, use of biological membrane, deferring temporarily or permanently the placement of planned implants be at the sole discretion of the attending dentist. There may be involvement of the sinus cavities when the implants are placed in the upper jaw. Alternative treatments have been explained to me as well as the option of doing nothing. I understand the risks of no treatment may include, but are not limited to: loss of bone and gum tissue; jaw joint problems; headaches and referred pain; sensitivity; inflammation and infection.

I understand and accept the treatment recommended for me by my attending dentist. No guarantees have been made or implied. I also understand that implant supported prostheses require continuing professional monitoring, may require additional treatment in the future, and success is dependent upon home care. I realize implants may become loose and need to be removed or replaced.

I decline the above option and elect to proceed with a compromised treatment plan. I understand that consequences of my decision not to have treatment may be, but are not limited to: loss of bone and gum tissue; jaw joint problems; headaches and referred pain; sensitivity; inflammation and infection. I also understand that I will be provided with other hygiene visits to review treatment options.

Treatment risks/unwanted consequences of the proposed implant treatment may be (but are not limited to):

- Reaction to medications/anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, face, tongue, and gums
- Damage to nearby teeth and restorations
- Post-treatment swelling
- Bruising, bleeding, or infection
- Sensitivity, pain
- Poor aesthetic result (involving appearance)
- Failure of implant integration
- Sinus infections/complications

I accept the fiduciary responsibility for all treatment rendered, to include any additional treatment that may become necessary for optimum results. I acknowledge that restoration and its associated fees are separate from implant placement fees. The proposed treatment and estimated fees have been explained to me, or have been made available upon my request, as have any third party benefits. I understand that third party benefits may be different than discussed as they are not under the control of this office.

I have been offered a copy of this consent form for my records. All of my questions have been answered and I understand that should I have additional questions or any concerns regarding post-operative signs or symptoms, I will immediately call Dental Health Associates at (301) 439-7878 for a phone consultation or follow-up visit. I also acknowledge that should the office be closed, I will contact the after hours attending dentist with the phone number on the Dental Health Associates voice mail.

Patient _____ Date _____

Witness _____

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 access to 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 April 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 from third party 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 e-mails, text, 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 in accordance with guidelines as provided by the Maryland State Board of Dental Examiners. 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 $1.00 for each page, $20.00 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.

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 Officer: Alan R Wolcott, D.D.S. Phone #: 301.439.7878 Fax #: 301.434.3448

HIPPA and other policies and procedures are available for review @ dentalhealthinfo.com

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES *You May Refuse to Sign This Acknowledgement*

I have been informed of this office's Notice of Privacy Practices and I am aware that there is a copy posted in a common area. HIPPA and other policies and procedures are available for review @ dentalhealthinfo.com and are available in printed format on request.

_____ _____ _____

Name Signature Date NS+LN

Appendix 2.2: Instructions

Bleaching Instructions for At-Home Mouthguard Bleaching

You will be given a mouthguard. Please store the mouthguard on the model of your teeth when you are not using it. When the mouthguard is being stored, before placing it on the model, clean it thoroughly with a wet toothbrush to remove any food, plaque, or debris in the mouthguard.

1. Try in the mouthguard to assure that it fits snugly without rubbing on any of the gums or cheeks. If it is rubbing in an area, return for an adjustment. If the mouthguard causes tooth soreness when biting, also return for an adjustment. Take the mouthguard out of your mouth and apply several drops of bleaching gel to the areas being bleached. You can run a small bead of bleaching get so that only 1/3 of each tooth indentation is filled.
2. Before placing the mouthguard with the bleaching gel in your mouth, thoroughly brush your teeth with Rembrandt toothpaste and floss your teeth.
3. Place the mouthguard with bleaching gel into your mouth making sure it is fully in place on all of the teeth. Any excess bleaching gel that is present should be wiped off the gingival using a facial tissue. For the best results, refresh the bleaching gel every hour. For the fastest results wear the mouthguard for at least two hours every day. If the mouthguard is worn at night while sleeping, it is advisable that during the night you refresh the bleaching gel.
4. It is extremely important that you return to the office every 2-3 weeks to check on the progress of the lightening effect and to make sure the gums and teeth are fine.

If there are any problems—mouth ulcers, sore spots, tooth sensitivity, burning sensations—stop wearing the mouthguard immediately and call the office. We will schedule you an appointment to evaluate the problem

Instructions Prior to all Dental Surgery

Instruction Prior to Implant Surgery

- **Do not** take Aspirin or any product containing Aspirin 7 days prior to surgery
- **Do not** drink alcoholic beverages for 1 day prior to surgery
- **Do not** drink caffeinated beverages the day of the surgery
- **Do not** wear make-up (foundation or lipstick)
- **Do** wear comfortable, loose fitting clothing
- **Do** eat a meal before arriving at the clinic
- **Do** take the pre surgical prescribed medication

Instructions After Implant Surgery

- **Do** use ice on your face (20 minutes on/ 10 minutes off) for a total of 24 hours
- **Do** drink ice water for the first 24 hours
- **Do** eat yogurt and ice cream for the first 24 hours
- **Do** eat soft foods for 1 week (chewing away from the surgical area)
- **Do** sleep with your head elevated for two nights following surgery
- **Do** rinse gently with water after each meal to cleanse the surgical wound

- **Do not** drink hot liquids for 24 hours following surgery

(Hot coffee, hot tea, hot soup)

- **Do not** brush the area of the surgery for 1 week or until instructed to do so
- **Do not** smoke for two weeks following surgery
- **Do not** drink alcohol for one week following surgery
- **Do not** use toothpaste until sutures are removed
- **Do not** exercise for three days following surgery (aerobic activity)
- **Do not** wear removable dentures until specified

(Wearing dentures too early will jeopardize healing)

Bleeding

- You may see some bleeding following the surgery. If this occurs, it may be stopped by gently biting on gauze soaked in cold water. If the bleeding is not controlled by this method, please contact our office.

Swelling

- Cold pack for first 48 hours
- If swelling is going to occur, it will peak at 48-72 hours following the surgery
- If you are swollen after the first 48 hours heat may be used on the area
- A moist heated towel or a hot water bottle may be used in the area of swelling after 48 hours
- In some cases bruising or restricted jaw movement may occur. Heat after the first 48 hours will help reduce these symptoms

Sutures

- Sutures will be present in your mouth following the surgery. Avoid the area of these sutures
- These will be removed in approximately 7-14 days following the surgery

Medications

- In some cases medications will be prescribed
- Mouthwash (Chlorhexidine) should be used twice a day for 30 seconds, after breakfast and before bedtime
- Use prescribed medications as directed
- If you have mild discomfort take non-prescription medications that do not contain aspirin, such as Tylenol or Advil

Emergency Telephone Number

Dental Health Associates PA (301) 439-7878

Post-Operative Instructions

1. As the anesthetic wears off, you may experience some discomfort. The medication labeled _____is for pain relief. Take this medication as prescribed at the instructed time intervals. Do not substitute aspirin or other medications unless you are instructed to do so. If this medication causes adverse side effects, call the telephone number at the bottom of this page.
2. Immediately following the procedure, an ice pack should be applied to your face in the area of the surgery, using it for 20 minutes and then removing it for 10 minutes. (Be sure to replace with fresh ice as needed). This should be continued for the rest of the day, as it helps prevent swelling and subsequent pain.
3. There may be occasional blood in your saliva during the first day. This is expected and normal. Excessive bleeding is neither expected nor normal. If there is excessive bleeding, call us. Do not do any rinsing or spitting today.
4. Clean the teeth that were involved in the surgery as well as you can, according to how you have been instructed. However, do not use a toothbrush on the surgical area for the first day.
5. For at least the first and second day, you should eat a soft diet with warm or cold temperatures. You may choose soups, puddings, milkshakes, yogurt, etc., or you may use food supplements such as Sustecal, which can be purchased at your pharmacy. Do not use a straw and do not eat spicy foods.
6. On the second or third day, return to a normal diet. Be sure to eat a well-balanced diet, but do not eat any nuts or "shell"-type foods such as popcorn.
7. In addition to your pain medication, you may have been given a prescription for an antibiotic and/or steroid_____. It is absolutely essential that you take all of these pills exactly as the prescription label states, and that you do not stop taking them until they are finished. Take them either one hour before or after eating meals and do not take them with milk or any other dairy products. Avoid sunbathing and drinking alcohol while you are taking the antibiotic. Should you experience skin rash or gastrointestinal distress, call the telephone number at the bottom of the page.
8. A surgical dressing may have been placed in your mouth in the area of the surgery. At a future appointment, it will be removed and possibly replaced. Before then, if a little piece of the dressing comes off (less than ¼) do not worry. If the dressing gets loose or more than half of it comes off, contact our office. If you have a removable partial denture placed over the dressing, leave it in until your next appointment.
9. Try to avoid excessive movement of lips and tongue. Do not try to look at the surgical area by opening your mouth wide and do not touch the surgical area with your finger or a foreign object.
10. If you had sinus surgery, do not blow your nose or take an over-the-counter decongestant such as Sudafed. It will help to breathe through your mouth for the first day.

Post-Extraction Instruction Sheet

1. Bite firmly on the supplied gauze dressing for at least 60 minutes. Try not to allow the gauze to move while covering the extraction site.
2. If bleeding persists following the removal of the original gauze dressing, insert a new gauze moistened with tap water and continue biting firmly on the gauze for another 60 minutes. A small amount of oozing is normal for up to 24 hours. If noticeable bleeding occurs or persists beyond this time, fold a gauze sponge, wet it, place it over the extraction area, and contact the office right away.
3. Swelling in the area of the extraction site may occur after an extraction. *To minimize swelling, use cold on the day of surgery, and heat on later days*.
    - On the day of surgery, place an ice pack on your face over the area of the extraction. The ice packs should be left on for twenty minutes, then removed for ten minutes. Continue this pattern of cold on – and – off for six to twelve hours. The earlier this is started, the more effective it will be.
    - To control swelling the day after surgery, you should use moist heat such as a heating pad, hot water bottle, or warm wash rag. This does not need to be alternated on and off to help relieve discomfort and reduce swelling.
4. Rest for the remainder of the day. Do not do <u>anything</u> strenuous. When lying down, it is best to be in a semi-reclining position.
5. The fact that you have had oral surgery does not mean that you should refrain from eating. Proper nutrition will aid in the healing process. You will want to eat soft foods such as scrambled eggs, pancakes, soups, applesauce, etc, for the first 24 hours.
    - **Drink plenty of fluids, but do not drink through a straw**
    - **Do not spit or rinse your mouth until the day following surgery**
    - **Do not smoke for at least 48 hours following surgery**

Doing any of these things may cause increased bleeding or loss of the healing clot, increasing your chances of having a dry socket.

6. 24 hours after surgery, begin gentle rinses of your mouth with a glass of warm salt water (1/2 teaspoon of salt in the glass of very warm water). Repeat three or four times during the day.
7. Brush your remaining teeth normally and clean the surgical area as well as you can.
8. If your doctor has prescribed any medications for infection or pain follow the instructions carefully. Do not take pain medications on an empty stomach.

Post Oral Surgery Instructions

How to care for your mouth after oral surgery:

Swelling: Apply a cold wet towel or an ice bag to the side of your face. Leave it on for 20 minutes, then off for 10 minutes. This may be repeated for up to 4 hours. Do not use ice after 4 hours.

Pain: Take the medication as directed by your dentist, listed below:

Take _____every_____hours as necessary for pain

Bleeding: Fold a clean piece of gauze to the size of your thumb, dampen it with cold water and press it into the wound. Bite down firmly for 30 minutes. Sit upright and remain quiet. Repeat this if necessary.

Mouth Rinse: After 12 hours, you may rinse your mouth with warm salt water. Mix ½ teaspoon of salt in a glass of water. This can be used before and after meals.

RETURN TO THE OFFICE IF YOU ARE NOT ABLE TO CONTROL EXCESSIVE BLEEDING, SWELLING OR PAIN. THE TELEPHONE NUMBER OF THE OFFICE IS (301) 439-7878. IF THE EMERGENCY HAPPENS AT NIGHT OR ON WEEKENDS, CALL THE NUMBER ON THE OFFICE VOICE MAIL.

Implant Surgery Pre-Operative Instructions

- DO NOT take Aspiring or any product containing Aspiring 7 days prior to surgery
- DO NOT drink alcoholic beverages for 1 day prior to surgery
- DO NOT drink caffeinated beverages the day of surgery
- DO NOT wear make-up (foundation or lipstick)
- Do wear comfortable, loose-fitting clothing
- Do eat a meal before arriving at the clinic

Implant Surgery Post-Operative Instructions

- Use ice on your face (20 minutes on/10 minutes off) for a total of 48 hours
- Drink ice water or use ice chips in your mouth for the first 24 hours
- Eat soft foods for 1 week (chewing away from the surgical area)
- Sleep with head elevated for two nights following surgery
- Do not brush the surgical area for 1 week or until instructed to do so
- Rinse with water after each meal to cleanse the surgical wound

- Do not drink hot liquids for 24 hours following surgery (hot coffee/hot tea/hot soup)
- Do not smoke for 2 weeks following surgery
- Do not drink alcohol for 1 week following surgery
- Do not use toothpaste until sutures are removed
- Do not exercise for three days following surgery (aerobic activity)
- Do not wear removable dentures unless specified (wearing dentures too early will jeopardize healing)

Bleeding
- You may see some bleeding following the surgery. If this occurs, it may be stopped by gently biting on a gauze soaked in cold water and wrung damp. If the bleeding is not controlled by this method, please contact our office.

Swelling
- Use a cold pack for the first 48 hours
- If swelling is going to occur, it will peak 48-72 hours following the surgery
- If you are swollen after the first 48 hours, heat may be used on the area
- A moist heated towel or a hot water bottle may be used in the area of the swelling after 48 hours
- In some cases, bruising, or restricted jaw movement may occur. Heat after the first 48 hours will help reduce these symptoms

Sutures
- Sutures will be present in your mouth following the surgery
- Avoid the area of these sutures
- These will be removed approximately 7-14 days following the surgery

Medications
- In some cases, medications will be prescribed
- Mouthwash (Chlorhexidine) should be used twice a day for 30 seconds, after breakfast and before bedtime
- Use prescribed medications as directed
- If you have mild discomfort, take non-prescription medications that do not contain aspirin, such as Tylenol or Advil

Immediate Dentures

1. You will be given an appointment for the day following the removal of your teeth and the insertion of your dentures. Do not remove your dentures the first day, even to clean them. They will be removed, cleaned, and adjusted by the dentist who made them. Wear your dentures 24 hours a day for the next six days, taking them out only to clean them. After the first week, leave your dentures out at night.
2. Take your dentures out after meals and at bedtime and clean them carefully. The best cleaner is plain soap, something like Ivory Liquid. Use a denture brush to clean them. Do not scrub too hard, but try to work the bristles into crevices and hard to clean areas.
3. After the first 24 hours (when the denture should not be removed) you may want to rinse your mouth with warm water (1 cup of water with ½ teaspoonful of salt) to reduce the swelling. Rinse with salt water while you have your dentures out to clean them. As your mouth becomes less sore, massage your gums with a washrag wrapped around your finger.
4. A healthy diet is important during the first few days of healing even though your mouth is sore. Milk shakes, ice cream, scrambled eggs and other easy to chew foods are good, but do not worry about causing injury to your gums. Eat anything that does not cause excessive pain. Learning to chew with dentures takes time. Try taking very small portions of food at first.
5. Several denture adjustments are usually necessary during the first few days. Report to the dental office as soon as possible when you are having problems.
6. The first three days will be the most uncomfortable. After that period each day brings improvement so do not get discouraged. You will get better.
7. Frequently when many teeth are taken out at one time, stitches will be placed to control bleeding. The doctor will advise you at the time of surgery if and when these stitches have to be removed.
8. After initial healing, your dentures will become loose as your gums heal. After six weeks we will reline your dentures to compensate for shrinkage of your ridges. You should report to the dental office regularly so that your healing can be checked. You will be given an appointment for the reline procedure. The day of the reline, you will be without your dentures for about seven hours, so plan accordingly.

Appendix 2.3: Letters

Final Notice Letter

August 19, 2011

Guarantor,
8901 New Hampshire Avenue
Silver Spring, MD 20903

RE: (Patient Name) Past Due Account Balance

Dear Guarantor,

(Patient's name) account with Dental Health Associates, PA is more than ninety (90) days past due in the amount of ($_____). Your immediate attention is required to this urgent matter as this is our final notice to you. Subsequent to this letter you were notified of this debt and given ample time to pay. Attached you will find a copy of the statement previously sent to you indicating your past due balance.

On (**September 14, 2011**), should the account balance remain unpaid and in past due status, we will initiate our collection process. Please understand that this outstanding account balance could jeopardize your credit rating. We trust this will not be necessary.

Once again this is our final notice.

Sincerely,

(Name)
(Position)

Transfer Record Letter

Dental Health Associates P.A.
1734 Elton Road, Suite 231
Silver Spring, MD 20903
301-439-7878 Fax 301-434-3448

Dear _____

A request for a copy of dental records to be forwarded to you. I have found that an overview would be a more concise and efficient manner of introducing you to your new patient and help reveal past dental history and dental care trends.
A complete dental record review has revealed the following useful information:
.
Our records indicate _____ has been a patient in this office since_____.

Their last visit to our office was on _____for □ routine restorative/perio □ urgent care

The last Bitewings are dated _____ □ are less than twelve months old and have been copied and forwarded.
□ will not be forwarded due to a scheduled update.

The last Panorex is dated _____ □ is less than three years old has been copied and forwarded.
□ will not be forwarded due to a scheduled update.

The last periodontal re-care visit was planned on _____ for; □ prophy □ perio maintenance □ other

Dental care prescribed and provided has been	□ routine	□ limited	□ irregular.	
Overall dental health is considered	□ excellent	□ good	□ fair	□ poor.
Prognosis for a lifetime of problem free oral health is	□ excellent	□ good	□ fair	□ poor.

Prescribed restorative care is □ completed.
□ incomplete regarding the following issues:

Prescribed periodontal care is □ completed and on a recall interval of ___ mo.
□ incomplete regarding the following issues:

Additional items were scheduled for reevaluation;

Should you need any specific treatment information, please contact our office directly.

Sincerely,

Alan R. Wolcott, DDS mv in ot

Patient Collection Letter

DENTAL HEALTH ASSOCIATES PA
1734 Elton Road, Suite 231
Silver Spring, MD 20903
301-439-7878
Fax 301-434-3448

March 23, 2005

Ms. (NAME),
Your account has been sent to collections. As requested, this letter is to inform you of the steps taken prior to sending your account to our collections service. These steps are followed for every patient whose account enters a "past due" status, and are strictly followed by our billing department.

1) A statement is sent via mail to the patient's billing address (as listed in our system) at 30 or more days after service, informing the patient that a balance is outstanding on their account and requesting that they contact us to address this.
2) If the matter is not addressed at 60 days past due, another statement labeled "Past Due" is sent informing the patient that we have received payment from their insurance and that the listed balance is their portion. Patient contact is requested to address the matter.
3) At 90 days, if a balance is still outstanding, a third and final statement is sent with a "Final Notice" sticker prominently placed on the statement. This statement informs the patient that arrangements must be made at once or the account will be turned over to collections.
4) If the patient still does not contact our office, we attempt to contact the patient by phone (or patient's parent/guardian/guarantor) to inform them verbally of the situation and make arrangements. If we are unable to speak to an actual person, we will leave a message stating: the nature of the call, the office phone number and request that we be contacted before a specific date and time. We inform them (via message) that if contact is not made the account in question will start collection actions.
5) If contact is made, arrangements can be made very easily. If the patient either refuses to contact us or categorically refuses to make arrangements, we inform them that their account will be sent to collections.
6) Once sent to collections, no further action is taken on our part to contact the patient or otherwise address their balance. Should a patient initiate contact and want to address an account that's been sent to collections, we make every effort to assist them to satisfy their balance.
7) Ultimately, it is the patient's responsibility to satisfy all balances on their personal accounts. Statements and phone calls are a courtesy to try and settle any and all balances.

We hope that this helps to alleviate some of your confusion about the process that we use in these cases. In your specific case, we attempted to contact you by mail and by phone. In all of these attempts, we never received a response, and proceeded to the next step of the collection process.
It goes without saying how important it is to make sure we always have your most current contact information, as an acknowledgement of the situation can go a long way in these situations. If you have any further questions, please feel free to contact me at 301-439-7878.

Sincerely,

File: Patient Ledger
Ledger Note: Collection Start

Dental Health Associates PA
1734 Elton Road # 231
Silver Spring MD 20903
301.439.7878

Reg: Review of your Dental Account After your Insurance has Paid

Dear _____

We provide a face-to-face review of your dental ledger as a courtesy and to confirm we practice with translucency and honesty. If there are any errors in your account we hope to correct them at this meeting.

Your appointment is set for _____ _____ _____
date time with

Your review will include the following points / issues;

- patient payments,
- insurance payments
- insurance adjustments and
- residual balance.

Please review the attached documents prior to your appointment for this review.

The included documents are ;

- An explanation of an Insurance Payment option that your insurance company may have used. This is called an Least Expensive Alternative Treatment Provision (LEAT) or Alternative Benefit Provision (ABP)
    - Please note, we use the LEAT as the net result is the same
- A summary report of our ledger by date and procedure that includes;
    - patient payments,
    - insurance payments
    - insurance adjustments and
    - residual balance
- Copy of the dental ledger for the dates in question for your review

If you find any typographical or accounting errors please contact us in advance.

To compliment these documents, please review your Explanation of Benefits (EOB) prior to this review. Your insurance company is required by state law to send you a EOB. If you do not have your copy, contact your insurance company for a copy. EOB's can either be sent by mail or FAX, and sometimes by e-mail.

Please note, all EOBs' sent to our office are stored and will not be retrieved for or at this review.

Respectfully,

Alan Wolcott
Dentist

Patient _____ Date of service _____ Provider _____

Has insurance paid? Yes No

Has Insurance used Least Expensive Alternative Treatment Provision (LEAT)? Yes No

Please note;

1. Balances after insurance may not be defined for 1-6 months.
2. Your insurance company solely controls your insurance benefits, outside our office and outside our control
3. We make all reasonable efforts to maximize an insurance payment on your behalf
4. If the primary insurance does not respond in 60 days, the balance becomes the patients.
5. Secondary insurances will not accept a claim without an EOB from you primary insurance.
6. Therefore, We do not submit to the secondary insurance if the primary does not provide a EOB
7. We will not make any anticipated insurance adjustments until all insurance companies have responded with an EOB.
8. The maximum adjustment for any treatment is the greater of any EOB adjustment for that treatment and are NOT additive.

Least Expensive Alternative Treatment Provision. (LEAT) or Alternative Benefit Provision

"Where as the insurance company can independently select a lesser payable procedure whether or not that procedure is appropriate, correct, or clinically acceptable so that their financial responsibility is less. In doing so, a participating provider (dentist) will accept that payment and apply it to the treatment provided and accept that payment as the full responsibility of the insurance company." (There is no mention of the increased responsibility of the patient)

The LEAT provision is a cost saving measure; between your employer and your Insurance Company. Using LEAT, The insurance company honors their contractual agreements but ultimately pays a lesser amount. As your insurance company pays a lesser amount, you, the patient will pay a larger amount.

How this is done is, if there is an procedure that could replace the one done and has a smaller charge, they

1. Deny coverage on the submitted procedure (pay zero (0))
2. Change the procedure code to the lesser-priced treatment.
3. Process your claim on the lesser fee
4. Then pay their portion on the lesser fee
5. Note all of these benefit manipulations in the Insurance EOB (Explanation of Benefits).
6. We accept (but may not agree with) the EOB LEAT explanation and payment
7. The smaller payment is applied to your account
8. Leaving a larger patient balance than initially estimated.

According to your EOB the residual patient portion is less than what your dental bill is. This is true because; on your EOB.

1. Your EOB is purposely unclear on how your LEAT provision is applied under the Maryland State Insurance guidelines and your plan contract. Specifically,.
    a. We must accept and apply the payment to your account
    b. There is NO adjustment on the changed (LEAT) procedure code as that procedure was not done or billed by your dentist.
2. Your EOB may or may not show any adjustment that corresponds to the treatment provided, or billed on your claim.

We try hard to stay abreast of these changes but with over 900 dental plans in the greater Baltimore – Washington DC – Northern Virginia areas. Even with monthly insurance plan updates, our computer system can be only reasonably accurate.

As your policy changes or renews, so do the parameters of Insurance Policies. It is surprising to note that your benefits with your insurance plan are not released to us. Most insurance companies regard claim adjudication is proprietary and will only release broad estimates regarding payments. It is a fact, regardless of your insurance, they will not guarantee a payment for treatment that you have received and is covered.

Please look as two of our LEAT or APB examples on the next page.

LEAT Example One; A Routine filling.

1) Your dentist uses a tooth colored filling,
2) Noted in gray
   - An insurance company selects not to pay on a tooth colored filling and uses their LEAT and pays on a silver filling
3) You have an insurance benefit there will be an INSURANCE PAYMENT of 80/20 coverage
4) The question is 80/20 of what amount?

Accounting detail			math	**Fees**	**Ledger description**
Tooth colored filling	$100			100	Charge for tooth colored filling
Estimated Ins payment		80/20	@ 80% of $100 = $80		
Estimated Patient Payment		80/20	@ 20% of $100 = $20	20	Patient payment. Thank you
Actual insurance payment on a tooth colored filling			0	0	Insurance payment tooth color
Actual payment on a silver filling	$80		80% of $80 = 60	60	Insurance payment silver
			After insurance balance	20	Patient Balance after insurance
Additional patients portion (Insurance underpayment)				20	Patient payment. Thank you
			TOTAL BALANCE	0	

Your final bill represents an 80/20 payment but on a less expensive procedure which results in a patient paying $20 additional.

LEAT Example Two; Two fillings done on the same tooth the same day.

1) Your dentist does tow filling on the same tooth (one on the front the other on the side)

2) An insurance company selects not to pay on two one sided fillings but and uses their LEAT and pays on one two sided filling.
3) You have an insurance benefit there will be an INSURANCE PAYMENT of 80/20 coverage

4) The question is 80/20 of what amount?

(Insurance states 80/20 coverage)

Estimated at time of service			**Actual Ledger**	**Insurance Estimate of Benefits**		
Front tooth colored filling		100	100	125	Two sided filling fee	
Side tooth colored filling		100	100			
Front estimated Ins Pymt	@ 80%	-80	-100	-100	Estimated Ins Pymt	@ (80%)
Back estimated Ins Pymt	@ 80%	-80				
Front estimated Pt Pymt	@ 20%	-20	-20	-25	Estimate Pt Pymt	@ 20%
Back estimated Pt Pymt	@ 20%	-20	-20			
Estimated Balance		.00		0.0	Balance due on EOB	

Additional patients portion after insurance pays 60

Your final bill represents an 80/20 payment on a single two surface filling not two one surface fillings and does not represent a 80/20 payment. This happened because one of your treatments you received was denied for a cost saving procedure, which results in a patient paying $60 additional.

LEAT Example Three; you received a crown or an Onlay (they are equivalent 'coverage' restorations

Your dentist uses a crown/ onlay colored filling,

Noted in gray
An insurance company selects not to pay on a crown/onlay and uses their LEAT and pays on a silver filling

You have an insurance benefit there will be an INSURANCE PAYMENT of 50/50 coverage

The question is 80/20 of what amount?

Accounting detail		math	**Fees**	**Ledger description**
Crown/ onlay $900			900	Charge for tooth colored filling
Estimated Ins payment	50/50	@ 50% of $900 = $450		
Estimated Patient Payment	50/50	@ 50% of $900 = $450	450	Patient payment. Thank you
Actual insurance payment on crown/onlay		0	0	Insurance payment tooth color
Actual payment on a silver filling	$80 @ 80/20	80% of $80 = 60	60	Insurance payment silver
Insurance adjustment for a PDP crown/onlay			190	
		After insurance balance	200	Patient Balance after insurance
Additional patients portion (Insurance underpayment)			200	Patient payment. Thank you
		TOTAL BALANCE	0	

Your final bill represents an 80/20 payment on a less expensive procedure not the estimate 50/50 payment as was estimated which results in a patient paying 200 additional.

Your Portion after Insurance has paid

Accounting detail			math			**Fees**	**Ledger description**
							Charge for treatment
Estimated Ins payment	@	%	of	= $			
Estimated Patient Payment	@	%	of	= $			Patient payment. Thank you
Actual insurance payment on _____							Insurance payment tooth color
Actual LEAT payment on _____							Insurance payment silver
Insurance adjustment for a PDP						190	
			After insurance balance			200	Patient Balance after insurance
Additional patients portion (Insurance underpayment)						200	Patient payment. Thank you
			TOTAL BALANCE			0	

Outstanding Insurance Claim Final Letter

Dental Health Associates Pa
1734 Elton Road #231
Silver Spring MD 20903

Re: Account balance and Insurance issues

On _____
Date

Dear

I have personally signed this letter below to confirm that our manager has spoken to me regarding your account. As this matter is not yet resolved I would ask for your help and continued understanding.

First I would like to confirm that it is easier to send your insurance company a claim for payment than it is for us to send you a bill for the same thing. Please be assured a claim has been sent multiple times on your behalf, funny how they are never received. To help solve this issue may I recommend the following steps;

1. Please confirm that all of your personal information in our computers is correct. The information most needed is
    a. Correct name of policy holder and or patient
    b. Correct SSN of policy holder and or patient
    c. Correct Employer
    d. Correct Insurance Card
    e. Correct Plan #
    f. Correct Insurance Billing Address

2. If we have submitted on your behalf more than two (2) times,
    a. Please set a time whereas you can come into the office to re-submit your claim.
    b. We will have an additional claim printed, envelope labeled, and postage affixed and ready for you to place in the mailbox.
    c. We of course will provide you a copy of your claim for your records.

3. At your leisure, in about 2-3 weeks, please contact your insurance company for status of your claim. If they say anything other than your claim has been proceed and you have a check in the mail reimbursing you for your paid dental bill, we suggest you speak with a manager of your insurance company and your human resource manager at work.

I believe our continued participation in dental insurance provides a great benefit to our patients. It is a terrible interruption in our Doctor-Patient relationship when things like this happens. I also believe it is an embarrassment that your representative (your insurance company) could respond on your behalf in these ways.

As always, we act in your best interest because you the most important part of our office.

Respectfully submitted,

Alan Wolcott DDS
Dentist

45 Day Outstanding Insurance Claim Letter

Dental Health Associates PA
1731 Elton Road, Suite 231
Silver Spring, MD 20290
301.439.7878

May 2008

RE: First notice, 45 day Insurance Claim outstanding

Dear ,

It is unfortunate that we must let you know your dental insurance has not responded to our repeated claim submittals for the dental care you have received.

Your treatment was on: _____

YOUR CLAIM WAS SENT ON: _____

WE CONTACTED YOUR INSURANCE COMPANY ON: _____ AND SPOKE TO _____

YOUR CLAIM HAS BEEN RESENT BY E-CLAIM ON: _____AND MAIL ON _____

It is almost two months since you have received your dental work but you still have a balance due that will become your responsibility the next billing cycle.

As your insurance has not paid their portion of your bill, we ask that you to contact your insurance company.

I would like to confirm that it is easier to send your insurance company a claim for payment than it is for us to send you a bill. We submit all claims within 24-48 hours after treatment is provided. Maryland Insurance Law states that your insurance company must respond to a claim in no less than 30 days. Our office policy is if a claim is unpaid after 32-45 days, we try to contact your insurance company on your behalf and your claim is resubmitted most of the time electronically and by conventional mail. With continued non-payment, the un-paid balance is reverted to the patient after 60 days from the first time the claim was sent.

I know this maybe the first time you have been informed that you have an 'un-paid' dental bill. I believe it is an embarrassment that your insurance company did not respond on your behalf. As your insurance company is effectively your representative for partial payment, if your insurance does not pay, you become the default payer.

Before you call your insurance company, please review the enclosed copy of the claim we have sent to your insurance company (the original has been sent to them), and your dental ledger of your treatment. If you find any errors or mistakes contact me for a correction. When you speak with a claims representative, you may refer to the claim enclosed or fax this claim directly to them.

It is a terrible interruption in our Doctor-Patient relationship when things like this happen. I would like to thank you in advance for your help contacting your insurance company. We ask that you have confidence that your insurance company should be able to resolve this issue quickly. Both Dr. Wolcott and I believe dental insurance is a great benefit to many of our patients but our continued acceptance of your dental insurance must continue without repeating issues like this.

Sincerely,

Dr Wolcott

Dental Health Associates
e-cc. file / Dr. Wolcott

60 Day Outstanding Insurance Claim Letter

Dental Health Associates PA
1731 Elton Road, Suite 231
Silver Spring, MD 20290
301.439.7878
May 2008

RE: Final Notice, 60 day Insurance Claim outstanding

Dear ,

It is unfortunate that we must let you know your dental insurance has not responded to our repeated claim submittals for the dental care you have received.

Your treatment was on: _____

YOUR CLAIM WAS SENT ON: _____

WE CONTACTED YOUR INSURANCE COMPANY ON: _____ AND SPOKE TO _____

YOUR CLAIM HAS BEEN RESENT BY E-CLAIM ON: _____AND MAIL ON _____

YOUR UNPAID CLAIM HAS BEEN REVERTED TO YOUR BALANCE AND IS NOW DUE.

It is now two months since you have received your dental work but you still have a balance due that will become your responsibility the next billing cycle. As your insurance has not paid their portion of your bill, you may find it very important to contact your insurance company and have a reimbursement check sent directly to you.

I would like to confirm that it is easier to send your insurance company a claim for payment than it is for us to send you a bill. We submit all claims within 24-48 hours after treatment is provided. Maryland Insurance Law states that your insurance company must respond to a claim in no less than 30 days. Our office policy is if a claim is unpaid after 32-45 days, we try to contact your insurance company on your behalf and your claim is resubmitted most of the time electronically and by conventional mail. With continued non-payment, the un-paid balance is reverted to the patient after 60 days from the first time the claim was sent.

I know this maybe the first time you have been informed that you have an 'un-paid' dental bill. I believe it is an embarrassment that your insurance company did not respond on your behalf. As your insurance company is effectively your representative for partial payment, if your insurance does not pay, you become the default payer.

Before you call your insurance company, please review the enclosed copy of the claim we have sent to your insurance company (the original has been sent to them), and your dental ledger of your treatment. If you find any errors or mistakes contact me for a correction. When you speak with a claims representative, you may refer to the claim enclosed or fax this claim directly to them.

It is a terrible interruption in our Doctor-Patient relationship when things like this happen. I would like to thank you in advance for your help contacting your insurance company. We ask that you have confidence that your insurance company should be able to resolve this issue quickly. Both Dr Wolcott and I believe dental insurance is a great benefit to many of our patients but our continued acceptance of your dental insurance must continue without repeating issues like this.

Sincerely,

Dr Wolcott
Dental Health Associates
e-cc. file / Dr. Wolcott

Office Policy Regarding Submission of Dental Benefits

Dear Patient,

As a courtesy to our patients, we submit an Attending Dentist's Statement to their dental benefit company/insurance carrier for dental treatment provided in our office.

The Attending Dentist's Statements are submitted immediately after each appointment. The State of Maryland dictates benefit companies/insurance carriers must respond to a doctor's statement within 30 days of submission. Our office provides an additional 15 days as a reasonable "turn around" time for receipt of payment from a dental benefit company/insurance carrier. If payment is not received in 45 days, the dental benefit company/insurance carrier's portion will be transferred to the patient and will become due immediately. At the time when this outstanding balance is paid in full, we will provide the patient with a statement that can be submitted by the patient for reimbursement from the dental benefit company/insurance carrier.

Secondary dental benefits will be submitted only when the primary benefit company/insurance carrier responds and all outstanding "out of pocket" patient balance for that statement is zero.

When the patient's Primary dental benefit company/insurance carrier is a capitation or discount fee managed care plan that this office participates with, our contract with these companies states "the patient will be expected to pay all co-pays/member fees in full at the time of service." We will provide a statement to the patient that will assist them in requesting reimbursement from their secondary dental benefit company/insurance carrier. Or, we will submit a statement to the patient's secondary dental benefit company/insurance carrier on their behalf.

Although we do have information about many dental plans in our computer system, it is impossible to have current information on all of them. We ask that you contact your dental benefit company/insurance carrier with additional questions regarding your benefits. We can estimate benefits based on the latest schedules we have received, or based on historical data. However, until we have received the Explanation of Benefits from a dental benefit company/insurance carrier, we will not be able to determine your final outstanding balance for a particular statement.

Sincerely,

Alan Wolcott, DDS
Dental Health Associates, PA

Outgoing Patient Record Transfer Letter

DENTAL HEALTH ASSOCIATES P.A.
1734 Elton Road, Suite 231
Silver Spring, MD 20903
301-439-7878 Fax 301-434-3448

Dear _____

A request for a copy of dental records to be forwarded to you. I have found that an overview would be a more concise and efficient manner of introducing you to your new patient and help reveal past dental history and dental care trends.
A complete dental record review has revealed the following useful information:
.
Our records indicate _____ has been a patient in this office since_____.

Their last visit to our office was on _____for ❑ routine restorative/perio ❑ urgent care

The last Bitewings are dated _____ ❑ are less than twelve months old and have been copied and forwarded.
❑ will not be forwarded due to a scheduled update.

The last Panorex is dated _____ ❑ is less than three years old has been copied and forwarded.
❑ will not be forwarded due to a scheduled update.

The last periodontal re-care visit was planned on _____ for; ❑ prophy ❑ perio maintenance ❑ other

Dental care prescribed and provided has been ❑ routine ❑ limited ❑ irregular.
Overall dental health is considered ❑ excellent ❑ good ❑ fair ❑ poor.
Prognosis for a lifetime of problem free oral health is ❑ excellent ❑ good ❑ fair ❑ poor.

Prescribed restorative care is ❑ completed.
❑ incomplete regarding the following issues:

Prescribed periodontal care is ❑ completed and on a recall interval of ___ mo.
❑ incomplete regarding the following issues:

Additional items were scheduled for reevaluation;

Should you need any specific treatment information, please contact our office directly.

Sincerely,

Alan R. Wolcott, DDS mv in ot

Incoming Patient Records Transfer Letter

Date: _____

I, _____, authorize my Dental office,_____;

located at: _____

to release my personal information and my complete dental record for the following patient:

Patient: _____

Address: _____

_____

Tel: _____

Please forward my records to the following Dental Practice:

Dental Health Associates, PA
1734 Elton Road, Suite 231
Silver Spring, MD 20903

Signature: _____

Proposed Treatment Plan Text

Above we have provided a “guess-timate” of your dental insurance fees and payments

Your insurance carrier is the only entity that can adjudicate your claim for you. If you disagree with a benefit or payment amount, you must contact your insurance carrier directly as DHA has no authority to alter any decision or determination provided by your insurance carrier

Actual out of pocket cost may be different due to, changes in treatment at the time of service, plan administration, limitations and exclusions and is at the sole discretion of your insurance carrier.

Any portion of the fee associated with treatment listed or unlisted that becomes unpaid by dental benefits will be your responsibility and are due at the time of service.

Appointments one-hour or less rescheduled or missed with less than two (2) full business days notice will be assessed a fee of $30 per 30 minutes or fraction thereof .

Appointments greater than one-hour i.e. multiple services, surgeries, implants that are rescheduled or missed with less than two (2) full business days notice will be assessed a cancellation fee equal to the 20% deposit on account for the scheduled procedure.

Incomplete Treatment Letter

TO: _____

FROM: _____

DATE: _____

RE: _____

Our records show that your treatment is incomplete. We would like to assist you in obtaining optimum oral health. If you are interested in continuing with your dental treatment, please schedule an appointment by calling (301) 439-7878.

Sincerely,

_____

Letter of Dismissal

Send Certified Mail Return Receipt Requested (keep copy with file). Send regular mail also.

Dear _____ (patient):

My ability to continue to serve you by providing dental treatment has been compromised by _____ (reason/reasons).
(*Breaking appointments; non-acceptance of treatment recommendations; failure to follow treatment instructions; failure to pay bills; personality conflicts*).

Therefore, I am requesting that you seek dental treatment elsewhere. In the interim, The dentists and staff will remain available to treat you on an emergency basis for the next thirty (30) days. If we do not hear from you within that time, we will presume that you have made arrangements for future dental care elsewhere. We will be happy to forward your records when requested to the dentist of your choice.

Any TRANSFER OF RECORDS fees will be assessed and be satisfied prior to release.

Signature _____ (Dentist)

Date _____

New Patient Welcome Letter

June 7, 2012

Welcome Lori!

On behalf of the patient care coordination team, we would like to welcome you and your family into our practice. We appreciate that you have chosen us as your dental care team. Please know that the entire staff is committed to providing you with the highest level of personalized care as gently, thoroughly and efficiently as possible.

Our practice's ultimate goal is to help you preserve or restore healthy teeth, a healthy smile and fresh breath. To that end, we'll keep you on track with regular check-ups, top notch oral hygiene care, and expert dental treatment in a very comfortable environment. For more information about our Doctors, clinical staff, what services we offer, and our office please feel free to review our website at www.DentalHealthInfo.com.

During your first visit, the Doctor will perform a complete oral examination of your teeth and gums, take and/or review necessary x-rays, and make an assessment of your oral condition. If it is discovered that you need specific treatment to bring you to optimal dental health, a treatment plan and estimate will be prepared for you prior to beginning any procedures. You will have the chance to review recommended treatment and ask questions.

We believe every patient should understand the status of their dental condition and what is required to restore or maintain a healthy beautiful smile. We encourage you to voice any concerns you may have regarding your treatment, financial arrangements or just general interest in the latest dental technology.

Attached, you will find a health history form; please complete the first two pages and be sure to sign and date both pages. A Patient Care Coordinator will photocopy your identification card and, should you have dental benefits, a copy of your insurance card as well to confirm your benefits with your carrier. We are happy to apply your insurance and will electronically file claims the day after your treatment.

Thank you again for choosing our family practice. You have just joined a very special group of people… our patients.

Sincerely,

Charlene, Chris, Shannon, Marco, Lora & Wenda
Your very own patient care team!

Confidence in Office Safety Protocols

The news media has been reporting, almost on a daily basis, facts and information concerning the contraction of contagious diseases through medical and dental treatment. Because AIDS and other contagious diseases, such as Hepatitis B, are such important issues today, we feel it necessary to update you on the steps our office is taking to help prevent transmission of disease.

As a dedicated dental team, we are concerned about patient protection from infectious diseases. Each time a patient visits our office, a very special trust is placed into our hands. We do not take this trust lightly. That is why we are committed to providing maximum protection to you, our patient, against any kind of infectious disease. Many hours have gone into the design of our infection-control system. We are constantly evaluating and updating our procedures. The use of gloves, masks, protective eyewear and protective clothing are some of the more prominent steps that are taken to ensure your safety. These items are protection barriers against cross-contamination for our patients and ourselves. But what goes on behind the scenes? What steps are taken that are not so obvious to you, the patient?

Universal Precautions
To protect your health, we adhere to what is called "universal precautions." That means we use the same protective measures with every patient to prevent transmission of the virus that causes AIDS or any other infectious disease.

These universal precautions include:

- Wearing gloves and changing gloves between each and every patient;
- Wearing masks and protective eyewear for all patient treatment;
- Dental instruments are cleaned, bagged and autoclaved (steam sterilized) to kill all forms of disease after each use;
- Meticulously cleaning and disinfecting the surfaces in the treatment room and equipment after each patient;
- Disposing of needles and other sharp items in special containers;
- Using disposable products whenever possible to eliminate cross-infection as recommended by federal government guidelines and state and local regulatory agencies;
- Properly disposing of waste items and contaminated material;
- Handpieces are flushed and sterilized;
- Scrubbing our hands with an approved antibacterial soap before and after treating each patient.
- Many instruments are even disposable.

Our dental instruments are put through a system of ultrasonic scrubbing and then sterilized with a large, pressurized steam oven called an autoclave. An autoclave (steam sterilizer) kills all forms of disease. The instruments are packaged in such a fashion that ensures they are never touched before they are actually opened in the treatment room when they are touched with gloved hands. All hard surfaces, such as sinks and countertops, are wiped down with a disinfectant between each patient. These surfaces are then sprayed with a disinfectant, which can leave a slight lingering odor that you may notice upon being seated in the operatory. We also use a wide variety of disposable products, such as the plastic sheets covering the light handles, dental chair buttons, and drawer handles.

Infection Control
We autoclave (steam sterilize) our high speed handpieces (drills) after each and every patient use. In fact, we have a specially designed autoclave (Kavoclave) that is especially designed to be used to sterilize handpieces only. A sterilization indicator is used each time the autoclave is run. This indicator is used to verify that sterilization has taken place.

In our general purpose autoclave, which is used for all other dental instruments, we regularly use a spore testing kit which is sent to an independent laboratory to provide us with further confirmation that our autoclave is sterilizing properly.

We have installed anti-retraction valves in our dental units to prevent "pull-back" of any saliva or blood. The units are then flushed between each and every patient.

When our dental hygienists perform your Prophylaxis (cleaning), the entire "prophy angle" is disposed of. We use disposable materials as often as possible, such as the saliva ejectors and suction tips.

You may notice that the dental light, the light handles, the dental chair buttons and the dental unit arms are wrapped in clear plastic barrier wrap. The purpose of this is to act as a barrier from touching surfaces which can be contaminated. This plastic barrier wrap is changed between each and every patient.

We have a comprehensive infection control and hazards communication program within the office. This program is constantly being updated. It is in strict compliance with the National Center for Disease Control (CDC), the American Dental Association (ADA) as well as the Occupational Health and Safety Administration (OSHA) guidelines for the dental profession. We maintain very close monitoring of these procedures by constant training and updating. As a matter of fact, we have had other dental offices come to our office to observe our infection control procedures.

You may have noticed changes in types of procedures and methods from time to time. These changes are for your safety and benefit. The ultimate goal in infection control is to treat all patients the same, using universal precautions for everyone.

Our entire staff is very proud of the dedication and efforts we are taking to prevent the spread of contagious diseases, protect your health, and maintain the highest possible standards of infection control. Please feel free to ask us questions about our sterilization procedures. We want you to feel comfortable and confident that you are getting the protection and care you deserve as a patient here. We will be happy to give you a tour and let you see what we do. And if you have friends who are not comfortable going to the dental office, we will be happy to show them, too.

We feel that dental health is a must, and regular care is a requirement, and we want everyone to be relaxed, having no fears about any transmission of disease. We encourage you to ask questions if you would like any further details or information.

Chemicals Present in the Office Letter

DENTAL HEALTH ASSOCIATES, PA
1734 Elton Road, Suite 231
Silver Spring, MD 20903
(301) 439-7878
Fax: (301) 434-3448

4 April 2003

Maryland Department of Environment
Toxic Registries
2500 Broening Highway
Baltimore, MD 21224

Dear Ms. Troyer:

Enclosed is a copy of the chemical information list for all chemicals used in my dental office illustrating the location in which these chemicals are stored. If there is any additional information needed, please contact me directly.

Sincerely,

Alan R. Wolcott, DDS

Company Name: Dental Health Associates
Revision Date: November 17, 1999

BUSINESS ADDRESS:
Executive Court, Suite #231
Elton Road 1734
Silver Spring, Md. 20903

WORKPLACE ADDRESS:
Executive Court, Suite #231
Elton Road 1734
Silver Spring, Md. 20903

Contact Person: Dr. Ivonne G. Centty
Telephone: (301) 439-7878

COMMON NAME	CHEMICAL NAME	WORK AREA	DATE ADDED TO LIST
Accu-Film IV Brush On Liquid	Ethyl-Alcohol	T.R.	4/95
Acetone	2-Propanone	S.A.	4/95
Acid Etch Tooth Conditioner Gel	Phosphoric Acid Water Thickener Gel	T.R. S.A.	
Adhesive Hold	Toluene Isopropanol	S.A.	4/95
Adhesive Polyether	Toluene 2-Butanone	S.A.	4/95
Air Techniques Developer	Sodium Sulfite Potassium Hydroxide Hydroquinone Water	D.R.	
Air Techniques Fixer	Ammonium Thiosulfate Acetic Acid Sodium Sulfite Water	D.R.	
Air Techniques Formula 2000	Nitric Acid Thiourea Sodium Nitrate	D.R.	
Air Techniques Spray 2000	Sodium Hydroxide Water	D.R.	
Air Techniques Starter	Acetic Acid Sodium Bromide Water	D.R.	
Alginate Remover	Silicic Acid Disodium Salt	CAB	
Alkaliner Base Paste	N/A	S.A. T.R.	
Alkaliner Catalyst	Calcium Hydroxide	S.A. T.R.	
Astringedent	Ferric Sulfate	S.R. T.R.	
Astringedent Spot Remover	Phosphoric Acid	S.R.	
Autoclave Cleaner	Alkylphenol	S.R.	12/96
Birex	P-Tertiary Amylphenol #2-Phenylphend Phosphoric Acid Isopropyl Alcohol	S.R. T.R.	
Brush Cleaner	Methylene Chloride	S.A.	
Burning Alcohol	Normal Butane refill	LAB T.R, S.A.	1/30/97
Calcium Hydroxide Powder	Calcium Hydroxide	S.R. T.R.	
Camphorated Parachlorophenol	Parachlorophenol	S.A. S.	
Cavidry	Methyl Ethyl Ketone Ethyl Acetate (99%)	S.A.	
Cavit	Eugenol Oil Of Cloves	S.A. T.R	
Cavitec Accelerator	4-Allyl-2-Methoxyphenol	S.A.	
Cavitec Base	N/A	S.A.	
Chloroform	N/A	S.A.	

Cidex Plus.	Gluteraldehyde , .	S.A.	
Coecide XL plus sterilizing solution	Glutaraldehyde Sodium Nitrite	S.A.	1/97
Coe-Pak Accelerator	Zinc Oxide Vegetable Oil Mineral Oil Magnesium Oxide	S.A.	
Coe-Pak Base	Denatured Ethanol Petrolatum	S.A.	
Coe-Pak Retarder	Diethanolamine Thethanolamine	S.A.	
Coe-Soft Liquid	Dibutyl Phthalate Benzyl Salicylate Ethyl Alcohol	S.A.	
Coe-Soft Powder	N/A	S.A.	
Comspan-Catalyst	Triethylene Glycol Dimethacrylate Benzoyl Perioxide	S.A.	
Comspan-Opaque Base	Dimethocrylate Monomers	S.A.	
Comspan-Opaque Catalyst	Benzoyl Perioxide	S.A.	
Concise Enamel Bond System Resin A	Triethyleneglycol Dimethacrylate Bisphenol A Diglycidyl-Methcraylate N-N-Di-(2'Hydroxyethly-P-Touluidine) 2-(2'hydroxyl-5-Methylphenyl) Benzotriazole	S.A.	
Concise Enamel Bond System Resin B	Triethyleneglycol Dimethacrylate Bisphenol A Diglycidylmethacrylate Methacrylate Benzoyl Peroxide 2,6-Di-Tert-Butyl-P-Cresol	S.A.	
Copalite	Ethyl Ether Anlydrous Chloroform	S.A. T.R.	
Cutter Sil Paste Base	Polydimethyloxane	S.A.	
Cutter Sil Paste Hardener	Dibutyltindilaurate Silic Acid Ester/ Dibutylcrystapure	S.A.	
Cuttrol	Crystapure Basic Ferric Sulfate (Purified Salt)	S.A. T.R.	
Debubblizer	Water Glycerine	S.A.	
Delton Pit & Fissure Sealant (Opaque,Lightcure)	Aromatic/Aliphatic Dimethacrylate Titanium Dioxide,Silica Ethyl-P-Dimethy-Aminobenzoate Light Activators	S.A. T.R.	
Den Mat Cerinate Prime	Silinated DMS	S.A.	
Den Mat Core Paste Catalyst A + B	Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Creation-3-In-1	Dimethacrylate	S.A.	
Den Mat Crown Cementation Cat. Paste A	BPA Kimethacrylate - Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Crown Cementation Paste B	BPA Kimethacrylate - Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Crown Reline Cat. Paste A	BPA Kimethacrylate - Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Crown Reline Paste B	BPA Kimethacrylate - Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Dector	Acetic Acid	S.A.	
Den Mat Dry Bond	Alcohols Methylene Chloride	S.A.	
Den Mat Etchant	Ortho-Phosphoric Acid	S.A.	
Den Mat Geristore Conditioner	Aqeous HNO3 Oxalate Solution	S.A.	
Den Mat Geristore Paste A	Resin-Based Fluoro Alum. Silica Glass	S.A.	
Den Mat Geristore Paste B	Resin Based Fluoro Alum. Silica Glass	S.A.	
Den Mat Gold Link 2 Base A	Resin Based Fluoro Alum. Silica Glass	S.A.	
Den Mat Gold Link 2 Opaque B	Resin Based Fluoro Alum. Silica Glass	S.A.	
Den Mat Light Cured Resin	Methacrylates Dimethacrylates Photoinitiators	S.A.	
Den Mat Light Cured Ultrabond Powder	Silanted Barium Silicate Glass Alum. Silicate Glass	S.A.	
Den Mat Light Cured Zionomer Liquid	Resin Based Acidic Methacrylate	S.A.	
Den Mat Light Cured Zionomer Pastes	Resin Based Fluoro Alum. Silica Glass	S.A.	

Den Mat Light Cured Zionomer Powder	Fluoro Alum. Silica Powder	S.A.	
Den Mat Lighten Bleaching Gel	Carbamide Peroxide	S.A.	
Den Mat Non Setting Try-In Paste	Glass Fillers In Methacryalte Resin	S.A.	
Den Mat Paint On Dental Dam	Methacrylates	S.A.	
Den Mat Paste Laminate	Glass Fillers In Aromic/Alphatic Methacrylate Resin	S.A.	
Den Mat Perfection	Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Perfection Base Paste A	Glass Fillers In Methacrylate Resin	S.A.	
Den Mat Perfection Base Paste B	Glass Fillers In Aromatic/ Aliphatic Methacrylate Resin	S.A.	
Den Mat Polishing Paste	Glycerol Alumina	S.A.	
Den Mat Porcelain Bonding Agent	Alcohol Silane	S.A.	
Den Mat Porcelock Etchant	Hydrofluoric Acid	S.A.	
Den Mat Tenure Kit	2 Propanone	S.A.	
Den Mat Tetropaque Powder	Silane Glass Fillers	S.A.	
Den Mat Tetropaque Resin	Glycol Bisphenol DM	S.A.	
Den Mat Visar Glaze	Airomatic/Aliphatic Methacrylates	S.A.	
Den Mat Visar Seal Resin	Aromatic/Aliphatic Methacrylates	S.A.	
Den 0Mat Zionomer Conditioner	Aqeous HNO3 Oxalate Solution	S.A.	
Denstone	Gypsum Calcium Sulfate	LAB	
Disc soft lex.	Cured urethane backing paper. Alumminum oxide grit and binder.	T.R.	2/3/97
Dr. Thompsons Color Transfer Applicators	Organic Dye	S.A.	4/95
Duralay Liquid	Methylmethacrylates	S.A.	
Duralay Powder	Plasticized Poly Methylmethacrylates Kialkyl Phthalate	S.A.	
Durelon Liquid	N/A	CAB	
Durelon Powder	N/A	CAB	
Dycal	Calcium Hydroxide	T.R. S.A.	
Dycal Base	Zinc Oxide	S.A. T.R.	
Dycal Catalyst	Calcium Hydroxide Zinc Oxide	S.A. T.R.	
Dyract Flow	Polymerizable Dimethacrylate Resin Strontium Aluminum Fluorosilicate Glass Ammonium Salt of Dipentaerythitol Pentaacrylate Phosphate	S.A T.R.	5/99
Enzymatic Detergent	Subtilisin Dodecylphonolethoxylate Sodiumxylene Sulfonate Propylene Glycol Water	CAB	4/95
Etch Prep	Phosphoric Acid Water	T.R.	4/97
Eugenol	Oil Of Cloves	S.A. T.R.	
Flecks Cement Liquid	Phosphoric Acid Distilled Water Hydrated Alumina	S.A. T.R.	
Flecks Cement Powder	N/A	S.R. T.R.	
Formo Cresol	Cresol Formalin	S.A.	
Formula 2000	Nitric Acid Thiourea	S.A.	5/99
Ful-Fil	N/A	CAB	
Fynal Liquid	Eugenol	S.A.	

	Acetic Acid	T.R.	
Fynal Powder	Zinc Oxide	S.A. T.R.	
Gingibraid	N/A	CAB S.A.	
Glass Beads	Soda Lime Glass Zinc Oxide	CAB S.A.	
Medical examination gloves	Vinyl polymer	S.A	1/97
Helium	Helium	C.	
Hemoban	Aluminum Chloride	CAB S.R.	
Hemodent	Aluminum Chloride Propylene Glycol	CAB S.A.	
Herculite	Resin Light Activated Agent Filler	S.A. T.R.	
Hurricane Spray	Ethanol Denatured Alcohol Polyethylene Glycol Polyehtylene 400 Ethyl-P-Aminobenzoate Benzocaine Sodium Saccharin	S.A.	
Hybond Polycarboxylate Cement Liquid	N/A	S.A. T.R.	
Hybond Polycarboxylate Cement Liquid	N/A	S.A. T.R.	
Hybond Polycarboxylate Cement Powder	N/A	S.A. T.R.	
Hybond Zinc Phosphate Cement Liquid	Phosphoric Acid	S.A. T.R.	
Hybond Zinc Phosphate Cement Powder	N/A	S.A. T.R.	
Hypo-Cal Syringe	Calcium Hydrate -Calcium Hydroxide -Hydrated Lime -Lime Water -Slaked Lime	S.A. T.R.	
Impregum F Adhesive	Toluene 2-Butanone	S.A.	
Impregum F Paste, Base	N/A	S.A.	
Impregum F Paste, Catalyste	N/A	S.A.	
Impregum F Thinner	N/A	S.A.	
Impression Compound	N/A	S.A.	
IMS Daily Cleaner	Sodium Sulfate Urea Sodium Bicarbonate Sodium DD BSA Sodium Carbonate Sodium Tripolyphosphate Carboxymethycellulose	S.A. S.R.	
Insta-Fix Fixer	Sodium sulfite Ammonium thiosulfate Sodium Metabisulfite Borax Acetic Acid Aluminium Sulfate Citric Acid Water	D.R.	1/97
Insta-Neg Developer	Water Sodium Sulfite Hydroquinone Potassium Hydroxide p-Methylaminophenol Sulfate	D.R	1/97

IRM Liquid	Eugenol Acetic Acid	S.A. T.R.	
IRM Powder	Zinc Oxide	S.A. T.R.	
Jeltrate & Jeltrate Plus	Amorphous Silica Crystalline Silica Tetrasodium Pyrophosphate Potassium Alginate	CAB S.R.	
Jet Acrylic Liquid	Monomer Inhibited Methylmethacrylate	S.A.	
Jet Acrylic Powder	Plasticized Polymethylmethacrylates Diakyl Phthalate	S.A.	
Kavo Quick Spray	Freon Proponel Butane	T.R. S.R.	
Kavo Spray America	Freon Propane/Butane N-Octane Propane/Butane	S.A. T.R.	
Ketac-Cem Aplicap	N/A	S.A. T.R.	
Ketac-Cem Liquid	N/A	S.A. T.R.	
Ketac-Cem Powder	N/A	S.A. T.R.	
Ketac-Silver Aplicap Powder	N/A	S.A. T.R.	
Kodak GBX Developer/Replenisher	Hydroquinone -Water -Sodium Sulfite -Diethylene Glycol -Potassium Sulfite - Potassium Hydroxide	D.R.	
Kodak GBX Fixer/Repenisher	Water Ammonium Thiosulfate Sodium Bisolfite Sodium Acetate Boric Acid Ammonium Sulfite Aluminum Sulfate Acetic Acid	D.R.	
Kodar	PETG Copolyester	TR SA	1/97
Kooliner Liquid	Isobutyl Methacrylate 2-4 Dinydroxybenzophenone	S.A.	
Kooliner Powder	N/A	S.A.	
Lidocaine	Acetamide	T.R.	1/97
Listerine	Alcohol (Ethyl alcohol) Sorbitol Solution	T.R.	1/97
Luralite Impression Paste Acelerator	4-Allyl-2-Methoxyphenol	S.A.	4/95
Luralite Impression Paste Base	N/A	S.A.	4/95
Mepivacaine 3% plain	Mepivacaine Hydrochloride	T.R.	1/97
Mercury Magnet	Copper Zinc Iron Sulfamic Acid	S.A.	
Miracle Mix Alloy	Silver Metal Tin Metal Copper Metal	S.A. T.R.	
Mirror Defogger	Complex Organic Chemicals	S.A. T.R.	
Multi-Form - Eugenol	Propionic Acid	S.A.	
Multi-Form - Zinc Oxide	Turpentine	S.A.	
Neo-Plex Dental Impression Material -Accelerator	Titanium Dioxide Lead Perioxide	S.R.	
Neo-Plex Dental Impression Material -Base	Sulfur	S.R.	
Nite White	Carbimide Peroxide	S.R	

Nitrous Oxide	Di-Nitrogen Monoxide	S.	
Nu Gauze	Iodoform (Triiodomethane) Formaldehyde	S.A.	
Omnisil Adhesive	Trichlorotrifluoroethane	S.A.	
Orange Solvent	Mineral Oil Terpenes	S.A.	
Oraseal	Cellulose Glycols Silicones	S.A.	
Oxygaurd Gel	Polyetheeylene	CAB S.R.	4/95
Oxygen	Oxygen	S.A.	
P Ten Posterior Filling Material Paste A	Bisphenol A Diglycidyl Methacryalte Triethyleneglycol Dimethacrylate Quartz Silica Amorphous Silica 2-Propenoic Acid	S.A.	
P Ten Posterior Filling Material Paste B	Quartz Silica Triethyleneglycol Dimethacrylate Bisphenol A Diglycidylmethacrylate Amorphous Silicia 2-Propenoic Acid Benzoyl Peroxide	S.A.	
P-50 Prisma Resin Bonded Ceramic	Zirconia Silica/Silicon Dioxide Amorphous Silicia Bisphenol A Diglycidylmethacrylate Triethyleneglycol Dimethacrylate Z-Propenoic Acid, 2-Methylprophylester	S.A.	
Palgaflex Quick And Palgaflex	N/A	S.A.	
Panavia See Kit	Quartz Dimethacrylate Prosphorylated Methacrylate	S.A.	
Panavia 21 see kit	Quartz Dimethacrylate Phosphorylated Methacrylate	SA	12/96
Peri-Pro Developer	Sodium Sulfite Or Bisufite Potassium Hydroxide Hydroquinone Potassium Carbonate 1-Phenyl, 3-Pyrazolidone Water	D.R.	
Peri-Pro Fixer	Ammonium Thiosulfate Sodium Sulfite Or Sodium Metabisulfite Acetic Acid Sulfuric Acid Aluminum Sulfate Water	D.R.	
Perma	Hydrochloric Acid Silicon Carbide Silicon Dioxide	SR SC	9/95
Permadyne Base	N/A	S.A.	
Permadyne Catalyste	N/A	S.A.	
Permagum Base	N/A	S.A.	
Permagum Catalyste	N/A	S.A.	
Pressure Indicating Paste (PIP)	Dimethylpolysiloxane Zinc Oxide Proprietary	S.A.	
Prime & Bond 2.1	Methacrylates Acetone	T.R.	5/99
Prime & Bond Nt	Acetone Dipentaerythritol Pentaacrylate Phosphate Urethane Dimethacrylate Resin Polymerizable Dimethacrylate Resins	T.R.	5/99
Prisma APH	N/A Chemical Name	CAB	
Prisma Universal Bond 2 + 3 -Adhesive	Acrylic Monomer And Elastomer Glutaraldehyde	S.A. T.R.	

Probond Adhesive	Acrylic Monomer And Elastomer Glutaraldehyde	S.A. T.R.	4/95
Probond Primer	Ethyl Alcohol Acetone Acrylic Monomer And Elastomer	S.A. T.R.	4/95
Protect Dentin Desensitiser	Oxalic Acid Potasium Salt	CAB	
Protemp II	Dilauroyl Peroxide	S.R.	9/99
Ramitec Base And Catalyst	N/A	S.R.	
RC Prep	Ethylene Diaminetetra Acetic Acid Urea Perioxide Prophylene Glycol	S.R.	
Red Rouge Polish	N/A	CAB S.R.	4/95
Reprodent	N/A	S.R. T.R.	1/97
Sharpening Stone Oil	White Mineral Oil	S.R. T.R.	
Softone	Ethyl-Methacrylate Polymer	S.R.	
Speed-Clean	Ethylene Glycol Monobutyl Tetrapotassium Pyrophosphate Caustic Potash Water	SR	1/97
Stat Dri	N/A	CAB	4/95
Sulfamic Crystals	Sulfamic Acid	CAB	
Surefil High Density Posterior Composite	Urethane modified Bis-GMA Dimethacrylate Resin. Barium Boron Fluoroalumino Silicate Glass. Silica Fume.	T.R	5/99
Surgical Milk	Monoethanolamine Tetrasodium Salt Of Ethylene-Diamine Acetic Acid Polyoxyethylene 20 Oleyl Esther Polyoxyethylene 2 Oleyl Esther	S.A.	
Tater Stain Remover	Sulfamic Acid 1-Hexanol,2 Ethyl Hydrogen Sulfate Sodium Salt	T.R.	
Tech Spray (-96 Freezer)	Chlorodifluoromethane	S.R.	
Temp Bond Accelerator NE.	Ortho-Ethoxybenzoic Acid	T.R.	
Temp Bond Base NE.	N/A	T.R.	
TPH Spectrum Composite Material	N/A	T.R.	5/99
Trace 28 Dental Dislosing Solution	N/A	T.R.	
Tubli-Seal Root Canal Sealer Accelerator	Polypalc Resin Eugenol Thymol Iodide	S.R.	
Tubli-Seal Root Canal Sealer Base	Mineral Oil Zinc Oxide Corn Starch	S.R. T.R.	
Tytin-Precapsulated	Mercury Quick Silver	S.A. T.R.	
Ultradent LC Block-Out Resin	Aliphatic And Aromatic Methacrylate	S.R. T.R.	
Universal Silicon Adhesive	Xylol Ethyl Acetate	S.R. T.R.	
UP Root Canal Liquid	Eugenol	S.R. T.R.	
UP Root Canal Powder	Zinc Oxide Rosin Lump Bismuth Subcarbonate	S.R. T.R.	
V - K 4 Tarter & Stain	Sulfamic Acid Alkyl Ammonium Chloride	S.R. T.R.	

Vinylsiloxane Tray Adhesive	Methyl Ethyl Ketone Toluol Methylene Chloride Isopropanol	S.R. T.R.	
Vitrebond Glass Ionomer Liquid	Polycarboxylic Acid Copolymer Water 2-Hydroxyethyl methacrylate	TR CAB	1/97
Vitrebond Glass Ionomer Powder	Strontium Fluoro Alumino Silicate Glass Diphenyliodonium Chloride Disodium Phosphate	TR CAB	1/97
Wax- Baseplate-#3 Med. Soft	N/A	LAB S.R.	
Wax- Baseplate-Extra Tough	N/A	LAB S.R.	
Wax-Boxing	N/A	LAB S.R.	
Wax-Casting	Paraffin Wax Fume	LAB S.R.	
Wax-Inlay	Petrolieum & Vegtable Wax	LAB S.R.	
Wax-Occlusal Indicator	Paraffin Beeswax	LAB S.R.	
Wax-Occlusal Rims	N/A	LAB S.R.	
Wax-Orthodontic Trays	N/A	LAB S.R.	
Wax-White Utility Ropes	N/A	LAB S.R.	
Wax-Yellow Bite	N/A	LAB S.R.	
White Mineral Oil	N/A	S.R.	
Zinc Oxide	Zinc Oxide	S.R.	

Onlay Inlay Claim Letter

DENTAL HEALTH ASSOCIATES, PA
1734 Elton Road, Suite 231
Silver Spring, MD 20903
(301) 439-7878
Fax: (301) 434-3448

DATE: _____

RE: DENIED CLAIM # _____ SUBSCRIBER NAME/ID: _____

Dear Insurance Consultant:

Please reconsider your payment of this claim for tooth _____.

The service recommendation is for preservation of tooth structure with minimal tooth reduction. The adhesive characteristic of the bonded ceramic reduces cuspal deflection, flexure, deformation and increases strength and resistance to fracture while preserving the enamel. This procedure is not for aesthetic purposes. Rather, it is provided for its advantageous physical properties.

The bonded ceramic inlay/onlay strengthens and restores the tooth to near original condition (see references) while your recommendation of a mercury amalgam restoration is not sufficient because of its inferior physical properties. Amalgam fillings corrode at the margins allowing bacterial invasion. The mercury content creates physical deformations such as creep, dissimilar thermal coefficients and weakened tensile strength, which cause internal stress cracks, placing cusps at risk for fracture and structural damage. The tooth requires an adhesive ceramic inlay/onlay to properly protect it from cusp fracture during function.

On behalf of the patient, this letter serves as an official protest, per the **Wickline** and **Wilson** cases. The patient desires the most permanent, long-term restoration for the tooth. The patient has been notified of your denial and expects appropriate payment form their insurance company. Should the patient suffer future damages as a result of your inappropriate denial, you will be held responsible for any and all damages incurred.

Sincerely,

Alan R. Wolcott, DDS, PA

WICKLINE v. CALIFORNIA

23 Cal Rptr 810 (ct. App 1986)

UR-forced early discharge led to injury

"Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overruled."

WILSON v. BLUE CROSS OF SO.CAL

271 Cal Rptr 876 (1989)

Policy allowed 30 hospital days for depression. MD requested it. Gratuitous UR denied it. Pt committed suicide after discharge.

"The language in Wickline which suggests that civil liability for a discharge decision rests solely within the responsibility of a treating physician in all contexts is dicta."

So court found BC's refusal to pay a "substantial factor" in P's death. Note also poss. breach of contract.

Onlay Inlay Claim Supplemental Information Letter

DENTAL HEALTH ASSOCIATES, PA
1734 Elton Road, Suite 231
Silver Spring, MD 20903
(301) 439-7878/Fax: (301) 434-3448

DATE: _____

RE: Attached Inlay/Onlay Claim

SUBSCRIBER NAME/NUMBER: _____

Dear Insurance Consultant:

This letter provides supplemental information to aid your review of the claim for dental benefits for our patient because of the difficulty in determining necessary treatment when only x-rays are provided.

The service recommendation is for preservation of tooth structure with minimal tooth reduction. The adhesive characteristic of the bonded ceramic reduces cuspal deflection, flexure, deformation and increases strength and resistance to fracture while preserving the enamel. This procedure is not for aesthetic purposes. Rather, it is provided for its advantageous physical properties.

Tooth # _____ has:

- ❑ Multiple vertical fractures weakening _____ cusps
- ❑ Multiple horizontal fractures weakening _____ cusps
- ❑ Deterioration and margination of a previous large restoration was hiding significant decay
- ❑ The restoration exceeds 2/3 the intercuspal distance leaving enamel walls to be stabilized with an adhesive dental restoration to preserve as much tooth structure as possible.
- ❑ Completely replaces the _____ cusp
- ❑ Conventional treatment options would require a gold onlay or crown to protect the tooth from further fracture and/or breakage.
- ❑ Patient has a history of fracturing teeth.

This letter will also serve as a formal notice, per the **Wickline** and **Wilson** cases, of our responsibility advocating the appropriate treatment for this patient. Should this patient have suffered future damages as a result of an inappropriate insurance denial, the insurance company would be held responsible for any damages (See reference below). If we can be of further assistance, please contact our office.

Sincerely,

Alan R. Wolcott, DDS, PA

WICKLINE v. CALIFORNIA

23 Cal Rptr 810 (ct. App 1986)

UR-forced early discharge led to injury

"Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overruled."

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So court found BC's refusal to pay a "substantial factor" in P's death. Note also poss. breach of contract.

Appendix 2.4: Liability Forms, Releases, and Waivers

Liability Waiver

Pt. Initial:

Refusal of Recommended Radiographs

_____ This document will serve as evidence that I was informed of the need for necessary diagnostic X-rays and have voluntarily elected not to have this procedure performed, this being done against the recommendation of the attending Dentist/Hygienist.

_____ I assume full responsibility for any conditions relating to my dental health that may have been diagnosed had the X-rays been taken. I do not hold the Dentist/Hygienist liable for any failure to diagnose or any misdiagnosis due to lack of recommended diagnostic X-rays.

Pt. Initial: Refusal of Recommended Dental Treatment

This document will serve as evidence that I was informed that I have a dental disease or condition. I have been advised that the net, long term result of untreated disease can be any or all of the following conditions: tooth mobility, gum recession, spaces between teeth, sensitivity, pain, bleeding gums, bad breath, acute infections, and tooth loss (which can be disfiguring).

After receiving a full explanation of the proposed treatment, alternate treatment, treatment risks and risks if no
_____ treatment is performed, I have elected to receive NO TREATMENT at this time.

I assume full responsibility for any conditions relating to my dental health that may have been (un) diagnosed had treatment been provided. I do not hold the Dentist/Hygienist liable for any failure to diagnose or any misdiagnosis due to lack of recommended treatment.

I understand that any treatment provided is not treatment or correction of a Dental Disease and that if any treatment is performed; it will be done for palliative, sanitation and/or cosmetic purposes only.

The issues that were discussed are

_____ _____

_____

_____

_____

By signing below, I acknowledge that I have read this document, understand the information presented, have had all of my questions answered satisfactorily. I accept the risks and responsibility for the NO TREATMENT option as I have selected by initialing above. I will not hold the attending Dentist, the Hygienists, nor Dental Health Associates PA liable for any consequences to my oral or general health due to my refusal of treatment recommended.

I understand and accept that the staff, attending Dentist or Hygienist at Dental Health Associates PA reserve the sole right to refrain from providing any treatment and/or terminate any dental appointment or visit and Dr Wolcott reserves the right to release/dismiss the patient from the office for future care at will.

Patient Name:_____ Doctor/Hygienist:_____

Patient Signature:_____ Date:_____

Release of Liability Form

In consideration of the sum of (**zero dollars and zero cents**) (**$0.00**), I, (**Patient Name**), of (**Patient Address**), (**Patient City**), (**Patient State and Zip Code**), on this date of _____, and upon placing signature below, do hereby release (**Attending Dentist**) and Dental Health Associates, PA and any of their employees and agents, from any and all claims, suits, demands, and causes of action of whatsoever kind or nature for dental implant and periodontal surgical treatment previously provided to, and/or future dental treatment of (**relevant teeth/location**) to include all oral surgery, prosthetic, endodontic, periodontic, general restorative, orthodontic, and/or medical related treatment.

I understand that this is not an admission of liability of any type on the part of (**Attending Dentist**) and Dental Health Associates, PA and that this release contains the entire agreement between the parties herein.

I understand that, upon signing, dating, and returning the Release of Liability Form to (**Attending Dentist**) and Dental Health Associates, PA, I will receive a reimbursement in the total amount of (**$0.00**).

Acknowledged and agreed to:

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness	Witness Signature	Date

Medical Benefits Waiver Form

Dental Health Associates P.A.
Eligible Employees

This waiver will be taken at face value upon presentation to Dental Health Associates P.A.

This form must be signed and given to the Office Manager of Dental Health Associates P.A. no later than 7 days from your first day of employment.

----------Certification----------

I certify that to the best of my knowledge that I am qualified for the waiver and hereby apply to Dental Health Associates P.A. for the waiver.

I understand that Dental Health Associates P.A. has offered me full medical coverage starting the first day of the month following 90 days of employment for which I am waiving benefits.

I further understand and agree that this waiver will remain in effect until such time as I withdraw the request in writing. At that time, reinstatement of medical benefits are at the sole discretion of Dental Health Associates P.A. in accordance and allowed by the "in force" medical carrier.

Dental Health Associates P.A. reserves the right to change this waiver at anytime without notice.

_____	_____	_____
Employee Name	Employee Signature	Date
_____	_____	_____
Office Manager Name	Office Manager Signature	Date

Appendix 2.5: Miscellaneous Outgoing

Orthodontic Estimates Agreement

Estimated Treatment Fee:_____ Est. Number of Months:_____
Orthodontic Records:_____ Monthly Payments of:_____
Down Payment:_____
Estimated Insurance Benefits:_____ First Payment due:_____
Estimated Contract Amount:_____ Final Payment:_____

Orthodontic Charges:
We have employed a system utilizing a coupon book for monthly payments. You will **not** receive monthly statements.

The records fee is due at the time that the records are taken. We do not send monthly statements. In order to maintain our reasonable orthodontic appointment fee, we must insist upon regular monthly payments. We will assist you in processing insurance claims but the responsibility for non-payment or underpayment is yours (as well as your monthly payment). Your payments are due on the 10th of each month per your payment coupons. Please write your account number on your check. There will be a $5.00 late fee for payments received 10 or more days after the due date. In the event that this account is turned over for collection for non-payment, the contracting party will be responsible for all collection fees, court costs, and attorney fees.

Once active treatment has been completed, one set of retainers and one year of post-orthodontic treatment appointments will be included in your fee. Any office visits after the one-year retention period will require a minimal office charge.

If the above arrangements have been based on assignment of insurance benefits, any modification or termination of coverage and/or delay in payment of said benefits will necessitate re-negotiation of the terms of this agreement. We accept insurance benefits as a courtesy and a convenience to our patients, however, any amount not paid by insurance is the financial responsibility of the contracting party. Please understand that if your coverage is terminated for whatever reason, or if the patient does not have coverage, the usual and customary fee for treatment will be initiated. If treatment proceeds beyond_____, you will be responsible for $_____ per month for 12 months, or until the braces are removed.

Non-Compliance:
There will be an additional charge of $14.00 per brace for appliance abuse. This fee will incur if breakage occurs from the following: gum chewing, chewing pens, pencils, eating hard substances, improper brushing, etc. Additional charges will be made for lost appliances. The patient must wear the appliances as directed, keep appointments, and not lose, or destroy, the appliances. Excessive breakage will necessitate an additional charge to reinstate the appliances. Our services can also be discontinued for failure to adhere to financial arrangements. To avert any misunderstanding, we will be happy to discuss this information with you. Our appointments are scheduled at one-to-six week intervals. The frequency of visits has no bearing on the fee. A minimum $475.00 banding fee will be charged if treatment is discontinued for any reason.

General Examinations:
During orthodontic treatment your general dental care will continue to be the responsibility of your family dentist. It is imperative that patients planning to have braces bonded onto their teeth have a complete examination for cavities by their general dentist as well as a thorough cleaning prior to braces. Your general dentist should also be seen regularly during the period of orthodontic treatment for cleanings and check-ups at least once every 6 months. If the patient does not maintain reasonable oral health, cleanings may be recommended at shorter intervals.

Appointment Cancellations:
48 hours notice is required for rescheduling orthodontic appointments. A $15.00 charge per each 20 minutes will be assessed for all late cancellations or failed appointments.

I understand that this contract is an equitable estimate for services outlined in the attached treatment plan. I understand that this treatment plan may be changed during the course of treatment and additional fees associated with these treatment modifications will be separate from this contract.

In keeping with Title 1 of the Consumer Credit Protection Act, the U.S. Government requires us to inform you that there are NO finance charges and NO annual interest rate. You are required by that same law to sign this form.

I certify that I have read, understand, and agree with the contents of this form. I agree to the orthodontic treatment as outlined by the Doctor.

Patient Name_____

Responsible Party Name_____

Signature of Responsible Party_____ Date_____

HBV/HIV Test

I have been asked to have an HBV/HIV test due to an exposure incident. I accept/decline to do so.

_____
Printed Name

_____ _____
Signature Date

New Sections for Possible Placement or Removal

Staff Birthdays

January 1	Lora
March 2	Dr. B
March 8	Sandy
March 29	LaKishi
May 16	Dr. C
May 22	Ted
June 10	Dr. P-T
July 14	Chris
August 20	Charlene
October 27	Amanda
November 22	Sally
November 23	Sonya
November 27	Michelle
December 20	Dr. W
December 29	Wenda

Aetna
www.aetna.com/provweb
Username: dentalhealth001
Password: house001
Toll free: 1800.451.7715
John Matthews
Tel: 410.691.1422
Fax: 860.754.9694
matthewsje@aetna.com

Carefirst Blue Cross Blue Shield
https://provider.carefirst.com
Username: JonesA22
Password: Wolcott1
Toll free: 1800.842.5975
Kim Rothman
Tel: 410.605.2694
Fax: 410.720.5080
Kim.rothman@carefirst.com

Cigna
www.cigna.com
Username: wolcott1
Password: house001
Toll free: 1800.244.6224
Elyse Passwater
Tel: 954.514.6696
Fax: 860.967.7902
Elyse.passwater@cigna.com

Delta Dental
www.deltadentalins.com
Username: dentalhealth001
Password: house001
Toll free: 1800.616.3629
Gwen Turner (in network liaison)
Tel: 301.574.0166
Fax: 301.574.0366
gturner@deltadentalpa.org
Monica Wilson
Tel: 301.871.6345
Fax: 301.460.5314
mwilson@deltadentalpa.org

Delta Dental AARP
Toll free: 1866.261.4275

DentaQuest HMO
***Does not allow online verification for PPO's**
www.anslink.net/anspw.htm
Username: wltezq
Password: q80i83
Toll free: 1800.879.0288

Geha Connection Dental
www.geha.com
Username: dentalhealth
Password: house001
Toll free: 800.821.6136
Deidre
Tel: 800.505.8880 ext 4077
Fax: 816.257.4439

Guardian
www.guardiananytime.com
Username: dentalhealth001
Password: house001
Toll free: 1800.541.7846
Kevin Poindexter
Tel: 866.229.1970
Fax: 804.423.7823
Kevin_poindexter@glic.com

Metlife
www.metdental.com
Username: Wolcott
Password: wolcott
Toll free: 1800.275.4638
Sandy O'Connor
Tel: 908.393.9117
Fax: 908.685.0727
SOConnor1@Metlife.com

United Concordia
www.ucci.com
Username: dentalhealth008
Password: wolcott1
Provider #: 2081204
Toll free: 1800.332.0366
Vicki Everhart
Tel: 717.260.7574 ext 57574
Fax: 717.433.9874
Vicki.everhart@unitedconcordia.com

United Healthcare
www.unitedhealthcareonline.com
Username: wolcott1
Password: house001
1
Toll free: 877.842.3210
Nina Farley
Tel: 240.683.5224
Fax: 866.950.7631

Humana Dental
www.humana.com
Username: LoraBolinger
Password: Wolcott1
Toll free: 866.945.4426
Mary Murphy
Tel: 800.825.7869
Fax: 920.632.1288

Dentamax
www.dentemax.com
Username: Tax ID
Password: Wolcott1
Toll free: 800.752.1547
Jay Taylor
Tel: 248.327.5331
Fax: 866.658.0944

Assurant
Toll free: 800.442.7742
Leslie Delay
Tel: 800.434.2638 ext 2593
Fax: 816.556.7511

Dental Health Centers
Toll free: 800.879.0288
John Allen
Tel: 301.736.1400
Fax: 301.736.1635

Principal
Toll free: 1800.986.3343
Rita Moravec
Tel: 866.522.9407
Fax: 866.736.4736
Moravec.rita@principal.com

General Information

Perio-Vision
Toll free: 800.323.3370
Code # 147963
Eservices: 800-734-5561

Voicemail
Tel: 301.756.4100
Box #: 2804 Pin #: 1234

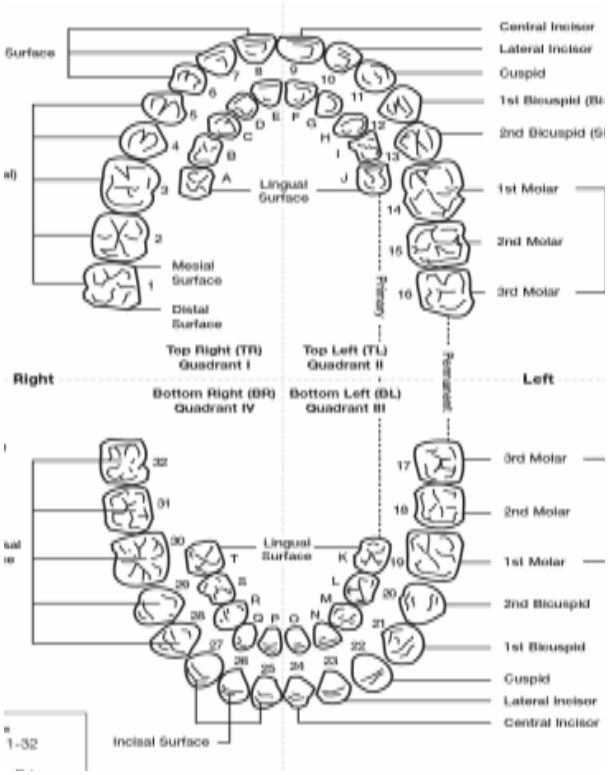
Fax
301.434.3448

Long Distance Code
3452

ALL APPOINTMENTS OVER SIX UNITS REQUIRE 20% DEPOSIT TO SCHEDULE!

ALL PERIO SURGERIES REQUIRE 20% DEPOSIT TO SCHEDULE.

NPI#s:	**License #**
Alan R. Wolcott	
1740292929	MD 11441
Tues-Fri	
Ivonne G. Centty	
1538334735	MD 11947
Mon. Wed. Fri.	
Cecile Poupard-Toner	
1225285091	MD 12600
Mon. Tues. Thurs.	
Alan L. Bernbach	
1356465108	MD 11590
Wednesdays	
Ibrahim Alhussain	
1871645929	MD 13503
Every other Monday	
Steven Keller	
1689701906	MD 6416
Some Thursdays	



DHA Insurance Plans

Aetna Dental Access PPO Schedule	1800.451.7715
Aetna(PPO)-918-**GP**	1800.451.7715
Aetna(PPO)-968-**SP**	1800.451.7715
Ameritas (Principal Fee Schedule)	800.247.4695
Assurant DHA	800.442.7742
BC/BS FEP Basic	800.842.5975
BC/BS FEP over 13	800.842.5975
BC/BS FEP to 13	800.842.5975
CareFirst Preferred PPO	800.842.5975
CareFirst Traditional	800.842.5975
Careington Platinum PPO/POS **Discount plan**	800.441.0380
Cigna PPO	800.244.6224
Cigna PPO/CoreNetwork	800.244.6224
Cigna Starbridge	800.244.6224
DBP (United Healthcare)	800.822.5353
Delta Dental-PPO	800.616.3629
Delta Dental-Premier	800.616.3629
DentaMax	800.752.1547
DHC local 639 or 730	888.802.6970
Dominion Dental PPO	888.681.5100
DQ Access ePPO **C**	800.334.6277
DQ Access ePPO **C2**	800.334.6277
DQ **Bravo**	800.334.6277
DQ Choice Dental	800.334.6277
DQ Managed Care **S5**	800.334.6277
Geha Connection Dental 07J	800.821.6136
Guardian	800.541.7846
Humana Federal Advantage	866.945.4426
Humana PPO	866.945.4426
Metlife	800.275.4638
Principal	800.275.4638
UCCI Reg 7(Nat'lFFS)	800.332.0366
UCCI Reg 55(ParNet)	800.332.0366
UHC PPO	877.842.3210