



# NEW PATIENT FORM

## Basic Information

Name	Gender	DOB
Preferred Name	Marital status	
SSN #	Employer	
Referral source	Referred by	Occupation

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## Contact Information

Mobile phone	Home phone	Street address
Email	City	State

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## Address Information

## Emergency Contact

Full Name	Street address		
Phone number	Relation	City	State

## Work Information

**Whitening for Life Program**

*Professional Teeth Whitening for Life is a courtesy and a privilege compliments of Elite Smiles PLLC. This program is extended to patients who have proven themselves as individuals who take their oral hygiene and general dental health seriously. We believe it is extremely important to maintain recommended hygiene care appointments and receive necessary dental treatment to maintain a healthy and beautiful smile. We pride ourselves on the smiles that leave our practice. Professional Teeth Whitening for Life was developed as a free gift for those patients who are already taking their dental health seriously, and as an incentive for those who need a little help keeping up with their dental care. Patients will receive a one-time custom made, professional take home whitening trays for personal use; plus (1) one whitening solution refills at each subsequent hygiene visit at no charge to the patient if program guidelines are met.*

While Professional Teeth Whitening for Life is a gift from us to you, the program does require some rules:

### **New Patients' Activation & Maintenance Guidelines**

New Patient of Elite Smiles PLLC to receive the no cost entry into the program.

Must be 18 years of age or older

Must complete initial hygiene cleaning, x-rays, doctor exam and re-appoint for (3 month, 4 month or 6 month) re-care. At that time of the re-appoint visit and necessary treatment has been started impressions will be taken for a professional whitening system and trays will be available within two weeks.

Must make all scheduled appointments. Cancellations must be made with a minimum 24-hour notice and original appointment rescheduled within the next two (2) weeks.

Will be disqualified from the program and given the opportunity to re-enroll for a \$100 re-activation fee if all guidelines are met.

Ask how to buy additional whitening tubes from one of our team members!

### **Existing Patients' Activation & Maintenance Guidelines**

Existing Patient at Elite Smiles PLLC and would like to join the program we charge a one-time fee of \$50 to receive the

custom whitening trays and (1) one tube of whitening (value of \$300).

Patient will be eligible to receive the trays within (2)

weeks of paying the \$50 one time enrollment fee.

Must be 18 years of age or older

Must complete initial hygiene cleaning, x-rays, doctor exam and re-appoint for (3 month, 4 month or 6 month) re-care. At that time impressions will be taken for a professional whitening system and trays will be available within two weeks.

Must make all scheduled appointments. Cancellations must be made with a minimum 24-hour notice and original appointment rescheduled within the next two (2) weeks.

Will be disqualified from the program and given the opportunity to re-enroll for a \$100 re-activation fee if all guidelines are met.

Ask how to buy additional whitening tubes from one of our team members!

### **Lifetime Maintenance Guidelines**

Must maintain continued hygiene care (3 Months, 4 Months or 6 Months Schedule)

Must comply with all Elite Smiles PLLC policies regarding payment or broken appointments.

Appropriate whitening solution refills will be presented at your hygiene visit.

Lost or destroyed trays will be replaced at cost to the patients for \$100 per arch.

*Disclaimer: Elite Smiles PLLC has the right to refuse this offer if deemed necessary; based on patient's health conditions, misuse, or abuse.*

Signature

**I consent to the above and agree to the Whitening for Life Program**

that is being offered to me. I do understand that this is an optional program available to me. I agree to the fees that are associated to the program as well.



## ORAL ABNORMALITY SCREENING CONSENT FORM

We are very concerned about oral cancer and conduct screening examinations on every patient that consents to the screening.

The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that since 2006, there has been a remarkable 61% increase in this deadly disease. Alarmingly, over 25% of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age and tobacco and alcohol use. In fact, it is now known that the same virus that causes cervical cancer, HPV (Human Papilloma Virus), is now becoming the leading cause of oral cancer.

Traditionally, our dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the VELscope has received FDA approval. The VELscope (Visually Enhanced Lesion Scope) will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage. The detected changes can range from something minor to something of greater concern that may require further examination and follow up.

**Oral Cancer risk factors are as follows:**

- Increased Risk: patients ages 18-39; sexually active patients (HPV)
- High Risk: patients age 40 and older; tobacco uses (any age, any type within 10 years)
- Highest Risk: patients age 40 and older with lifestyles consisting of using tobacco and/or alcohol

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire team. The normal fee for this procedure is \$80.00, however, the Doctor feels so strongly that every patient has this examination at least once a year. Our charge for this enhanced examination is only \$10.00. The encouraging aspect of your insurance is that this is the most you will have to pay out of pocket. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure. We do understand some insurance companies do not pay towards this procedure but we strongly encourage you to have the examination once yearly. If you have a high risk category then we encourage the examination to be 2x per year.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

**Please check YES or NO to accept the financial responsibility for this procedure.**

YES NO

If you check YES you will have consented for the YEARLY Oral Abnormality Screening Consent Form.

If you check NO you will be asked yearly if you would like to have the procedure.

Patient Signature

Date



**Elite Smiles PLLC**

303 S Concord Street Suite 323, Knoxville, TN 37919  
(865) 637-5708 [www.elitesmilestn.com/](http://www.elitesmilestn.com/)

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## PRIVACY POLICY CONSENT

### Client Rights And Hipaa Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 303 S Concord Street Suite 323, Knoxville, TN 37919:
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must

Patient Signature

Date



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## **STERILIZATION & BIOHAZARD FEE**

Elite Smiles PLLC applies a \$23 sterilization and biohazard fee to every appointment. This fee reflects the increased costs of sterilization, biohazard waste disposal, infection control supplies, and enhanced cleaning protocols implemented since COVID-19. The American Dental Association (ADA) recommended this fee beginning in May 2020, when dental offices reopened under stricter safety guidelines. If you have any questions regarding this fee, please don't hesitate to speak with a member of our front office team.

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## **MISSED APPOINTMENT POLICY**

Elite Smiles PLLC places great importance on the time that we reserve for you and your dental needs, and in doing so must count on our patients to allow us to better serve all patients needs, by honoring their selected times for treatment.

**WE REQUIRE A 24-HOUR NOTICE  
UNLESS MONDAY APPOINTMENT MUST BE CANCELED ON FRIDAY**  
for all cancellations and appointment changes.

**1st Occurrence: Document without fees**

**2nd Occurrence: \$50.00 Fee**

**3rd Occurrence: \$100.00 Fee**

**4th Occurrence: \$200.00 Fee**

Missed appointment fees will not be refunded nor applied to account balances, they are to compensate for the loss of productive Staff and Doctor time during your allowed missed/changed appointment time without required notifications. You will be charged per hour that your appointment is scheduled for.

Patient Signature

Date



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# PATIENT CONSENT TO BILL MEDICAL INSURANCE 1

## Patient Consent To Bill Medical Insurance

Our office utilizes claimSTAT Medical Billing LLC to provide billing services to medical insurance carriers for services rendered.

## Consent For The Use And Disclosure Of Health Information

I hereby authorize this office and claimSTAT LLC to release any information acquired in the course of my examination and/or treatment for the purposes of payment. I authorize the release of medical, dental, and/or health information to my insurers as necessary for determination and payment of benefits; to utilization review, associated companies, and community resources that assist me with my healthcare needs.

Patient Signature

Date

## NOTIFICATION OF PRIVACY

claimSTAT complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).



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## PATIENT CONSENT TO BILL MEDICAL INSURANCE 2

### Consent To Bill Assignment Of Benefits, And Payments

I authorize claimSTAT LLC, to file medical claim(s) to my insurance carrier for services rendered. I authorize this office to receive payment of benefits directly, for services provided to my dependent or myself. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services. I further understand that I will be enrolled, as needed, in claimSTAT Care Management Program, in the event that my insurance requires a referral from my PCP. This program is free and free of cost to the patient.

**\*Please Note:** Medical insurance reimbursements rates are different from standard dental rates. All reimbursement(s) from your medical insurance plan will be applied to your account based on medical allowable rates. As medical claims are being filed, the rate for services rendered will be adjusted to the standard medical allowed amount governed by CMS for the rendered service. In the rare event that your medical insurance denies the claim, your rate will be adjusted to the lower, standard dental rate. claimSTAT representatives are available to assist with any questions or concerns that you may have. You may reach claimSTAT at 800-668-2517.

I understand that I may revoke this consent in writing; however, my revocation will not apply to information already used or released in reliance on this consent or previously filed claims. I agree that a copy of this consent or revoking this consent, that no medical insurance will be billed for any services rendered. My signature below indicates that I understand and accept the content of this form.

Patient Signature

Date

Member First Name

Medical Member ID

Member Last Name

Member Date of Birth

Medical Insurance Payer

Medicare ID (if Applicable)

Patient Initials for Consent for the above statements.

Patient Name or Representative (print name)



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## FINANCIAL POLICY

### Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

### Insurance

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

### Payment

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist. This signed consent gives us authorization to treat your dental needs and are given us consent for all services performed. You are financially responsible for any services that are rendered.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 30 days old will be subject to a monthly interest of 15.0% (APR 15%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

### Missed Appointments

Unless we receive notice of cancellation 24 hours in advance, you will be charged **\$50**. Please help us maintain the highest quality of care by keeping scheduled appointments. All Monday appointments must be cancelled or rescheduled by end of business on Friday before the appointment to avoid a cancellation fee.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient Signature

Date



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## COMMUNICATION CONSENTS

### Email Consent Form

**PURPOSE:** This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Elite Smiles PLLC offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Elite Smiles PLLC will use reasonable means to protect the security and confidentiality of email information sent and received. However, Elite Smiles PLLC cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Elite Smiles PLLC and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Elite Smiles PLLC.

Patient Signature

Date



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## TEXT MESSAGE TO MOBILE CONSENT FORM

**PURPOSE:** This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Elite Smiles PLLC, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Elite Smiles PLLC will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Elite Smiles PLLC cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Elite Smiles PLLC and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Elite Smiles PLLC.

Patient Signature

Date