BREATHE WELL SLEEP SOLUTIONS

Date _____

Patient Registration

Patient's First Name / Middle Initial / Last Name / Suffix

_____

Preferred Name / Nickname _____

Date of Birth _____ Gender _____

Contact Details

1st Parent:

First and Last Name: _____

Relation to Patient (Mother, Father, etc.) _____

Address (Street, City, State, Zip) _____

Phone Number _____ Phone Type (mobile, home, work) _____

Email _____

Can we call you? (Circle) YES NO

Can we text you? (Circle) YES NO

Can we email you? (Circle) YES NO

2nd Parent (optional):

First and Last Name: _____

Relation to Patient (Mother, Father, etc.) _____

Address (Street, City, State, Zip) _____

Phone Number _____ Phone Type (mobile, home, work) _____

Email _____

Can we call you? (Circle) YES NO

Can we text you? (Circle) YES NO

Can we email you? (Circle) YES NO

Referrals

How did you hear about us? _____

BREATHE WELL SLEEP SOLUTIONS

APPOINTMENT POLICY

We encourage parents to relax in the reception room during the child's visit. This helps us develop a one-on-one relationship of trust and cooperation with your child and allows us to have their undivided attention.

Appointments are scheduled depending on the treatment needed and the age of your child. We will work with you to schedule an appropriate time for your child's age and treatment needs. **Small children are seen in the morning when they are their freshest. Older children will be seen in the afternoon. We will not always be able to schedule appointments after school therefore we are always glad to provide your child a school excuse.**

The length of appointments is planned exclusively for your child and allows enough time to accomplish the planned treatment. These times are scheduled with the utmost consideration for your child and his/her needs. It is very important that we are allowed to have the appropriate amount of time to spend with your child. If you are late for an appointment, this does not allow us the time we have reserved for your child and may delay the completion of treatment. This will possibly result in the need of another appointment, the child missing school and the parent missing work.

Initials _____ **PLEASE BE AWARE THAT IF YOU FAIL TO SHOW TO AN APPOINTMENT OR CANCEL LESS THAN 24 HOURS THERE MAY BE A FEE INCURRED OF $25.00.**

We recognize the value of your time. You can expect us to be on time for you and we would appreciate the same courtesy. We understand emergencies and other unforeseen things happening and occasionally, you will need to reschedule an appointment. **We request that you give us 24 hours' notice for a cancellation of an appointment.** This allows us to reschedule your appointment and let another patient have the time originally reserved for your child.

FINANCIAL POLICY

While we are committed to giving your child the best care available, it is important for you to know what the cost will be. You have the right to receive a good faith estimate of expected charges based on the treatment diagnosed by the Dentist. **Remember this is only an estimate.** Occasionally, during the course of treatment, other procedures may become necessary. We will strive to keep you informed if there are changes in the estimate. **At this time, we are not accepting insurance for these treatments.**

Payment is expected at the time of service. We accept cash, checks, money orders, Visa, American Express, and MasterCard.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

_____

Signature of Parent or Legal Guardian

_____

Date

BREATHE WELL SLEEP SOLUTIONS

Release & HIPAA Consent

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize this Healthcare Provider to use and disclose the protected health information described below

2. Effective Period

This authorization for release of information covers the period of healthcare for all past, present, and future periods.

3. Extent of Authorization

I authorize the release of my complete health record (including records relating to mental healthcare,communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be enforce and effect for 12 months at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at anytime.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of Parent or Legal Guardian

_____

Date