212-SMILING
314 West 56th Street, NY, NY 10019
(212-764-5464)

Yung K. Kim DDS, PC
www.212Smiling.com
ykim.212smiling@gmail.com

Today's Date: _____ DOB: _____ Patient Social Security #_____

Patients Name_____
(Last) (First) (Middle Initial) (Preferred)
Address_____

City_____State_____Zip_____

Drivers License # _____ Male/Female Single/Married/Child Other _____

Home Phone #_____Work Phone #_____Mobile #_____

Employer_____Occupation_____

E – Mail Address: _____

In Case of Emergency Contact:
Name_____Relationship_____Contact #_____

Who may we thank for referring you? _____

Account Information:
Individual Responsible for this account _____
(Last) (First)
Relationship to patient _____ DOB: _____Social Security #_____

Employer_____ Group #_____

Insurance Carrier _____Customer Service #_____

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions

Undersigned hereby authorizes Dr. Yung Kim to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Yung Kim to make a thorough diagnosis of patient's dental needs and may be used for educational purposes. I also authorize Dr. Yung Kim and Associates to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my conditions and further authorize and consent that Dr. Yung Kim chooses and employs such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services I rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. We bill Usual and Customary fees. Insurance payments are not guaranteed until received from the insurance company. If we agree to accept assignment, we charge the contractual co pay percentage and at the time of insurance payment make the necessary adjustment. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. In the event that full payment for charges incurred in connection with my dental care is not made, I agree to pay all costs of collection, including reasonable attorneys' fees, and interest at the rate of twenty-five percent (25%) of the whole balance. I agree to submit myself to the jurisdiction of the courts of the New York, NY. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. Please note not all providers and specialists are in network with all insurances and may not participate with your insurance plan.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____

Patient/Guardian Signature Date

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Physician's Name_____ Physician's Phone #_____
Physicians Address_____ CITY_____ ZIP_____

MEDICAL HISTORY

1. Are you in good health? _____ □YES □ NO
2. Has there been any change in your general health within the past year?_____ □YES □ NO
3. Date of last physical examination? _____
4. Are you now under the care of a physician?_____ □YES □ NO

If so what condition? _____

5. Have you ever had any serious illness, operation, or hospitalization? _____ □YES □ NO
6. Are you taking any drugs or medication? _____ □YES □ NO
7. List type amount and frequency if so_____
8. Are you using any recreational drugs? _____ □YES □ NO
9. Are you taking any over the counter drugs?_____ □YES □ NO
10. Are you sensitive or allergic to any medication? _____ □YES □ NO

□ Penicillin □ Sulfa □ Codeine/other Narcotic □Aspirin □ Barbiturates □ Iodine □ other _____

11. Do you have or have you had any of the following: (Please check known conditions)

□ Aids or HIV	□ Rheumatic Fever	□ Arthritis	□ Diabetes
□ Anemia	□ Blood Diseases_____	□ Head Injuries	□ Epilepsy
□ Artificial Joints	□ Sinus Trouble	□ Stomach Ulcers	□ Stroke
□ Heart Ailments	□ Sickle Cell Anemia	□ Venereal Disease	□ Heart Murmur
□ High Blood Pressure	□ Kidney Disease	□ Mental Disorders	□ Respiratory Disease
□ Tumors/Growths	□ Tuberculosis	□ Radiation treatment	□ Asthma/Hay Fever
□ Nervous Disorders	□ Allergies_____	□ Glaucoma	□ None of the above
□ Excessive Bleeding	□ Fainting Spells/ Seizures	□ Hepatitis, Jaundice or liver disease	

□ Other_____

If you checked yes to any of the above conditions, please give a brief explanation: _____

12. Do you use tobacco now or in the past?_____ _____ □YES □ NO
13. Do you wear a cardiac pacemaker?_____ □YES □ NO
14. Have you had Heart surgery? _____ □YES □ NO
15. Do you have any disease or condition or problem not list above that you think I should know about?
    If yes, what is it? _____ □YES □ NO
16. If you are female, are you pregnant or nursing? □YES □ NO If so, how many months? _____

DENTAL HISTORY

1. Previous Dentist_____
2. Was your pattern of visits regular infrequent sporadic
3. Have you been having any specific problems?_____ □YES □ NO

Explain_____

4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment? _____ □YES □ NO
5. Does dental treatment make you nervous? _____ □YES □ NO
6. Do you have or have not had any of the following: (Please check known conditions)

□ Bad Breath	□ Loosening of teeth	□ Bleeding gums
□ Clench your teeth	□ Sensitive Teeth at	□ Night □ Day □ Sweet □ Temperature
□ Cold sores	□ Grind your teeth at.	□ Night □ Day □ Hurt □ Lock □ Jaw Pop

7. Have you ever had any serious trouble associated with any previous dental treatment? □YES □ NO
8. Have you ever had any of the following: □ Injury □ Oral Surgery □ Orthodontics □ Periodontics
9. Do you like the overall appearance of your teeth?_____ □YES □ NO

_____

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NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how you health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An Example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in witting and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonably requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information to provide you with notice of our legal duties and privacy practice with respect to protect health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, retaliate against you for filling a complaint.

- For Information about HIPAA or to file a Complaint: The U.S. Department of Health & Human Services Office of Civil Rights – 200 Independence Avenue, S.W. Washington, D.C. 20201 – (202)619-0257 – Toll Free : 1-877-696-6775

Patient Consent Form

You May Refuse to Sign This Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Patient Name **Date**

_____

Signature

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ASSIGNMENT OF BENEFIT AGREEMENT

Please be informed that procedures are billed the day services are rendered. As a courtesy to our patients **212-Smiling** will send claims to the appropriate carrier for direct reimbursement. There is **NO guarantee** of payment. With your assistance, we will maximize coverage to lessen your out of pocket expense. We are in direct contact with the insurance carriers. In the event, that benefit coverage is un-assignable; the patient is responsible for the account before treatment is rendered unless otherwise specified. Once notification is received in the mail the patient is to forward a copy of the explanation of benefits (EOB) along with a payment in the same amount issued to them. If payment is not received within 30 days of the EOB, you will be billed the full account balance. Appeals and adjustments will be made accordingly. If no correspondence is received within 45 days of the date of service the entire fee (medical and dental) is due. Regardless, ultimately the patient is responsible for their account with Yung Kim, D.D.S, P.C. Financial arrangements are available upon request.

Signing this agreement confirms that you have been informed and agree to the above protocol. Feel free to speak to the financial coordinator with any questions or concerns.

_____

Patient Signature Date

CANCELLATION POLICY FOR APPOINTMENTS

We value both your time and ours. Please be informed that all appointments at 212-SMILING require a minimum of 48-hours cancellation notice. Any appointments that are cancelled within 48 hours will incur a $75 charge. We do understand that emergencies happen, but we will greatly appreciate when you contact the office to make all possible changes to avoid the fee.

You will be contacted 72 hours in advance to allow you to reschedule your appointment as necessary. You can contact our office by telephone, text, or email. As such, failure to notify the office of your inability to keep your reserved appointment directly authorizes us to charge your account if you do not keep your reserved appointment in the time slot that was assigned to you.

Signing this Agreement confirms that you have read, been informed of, and agree to the above protocol. Feel free to speak to our Patient Coordinator or Office Manager if you have any questions or concerns.

_____

Patient Signature Date