

DR. CHANG'S dental

(760) 256-9373 barstowdentistry.com

Financial Policy

Dental treatment is an excellent investment in your medical and psychological well-being. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Soonhyuk Chang, DDS INC requires your estimated payment prior to the completion of treatment.

For treatment requiring multiple appointments, alternative payment arrangements may be provided.

PLEASE NOTE OUR POLICY

Your co-pay is required to guarantee any future appointment times. It is required to pay your estimated share at the time your reservation is made. If you cannot pay at the time of scheduling, a call prior to your appointment will be scheduled to pay your estimated payment. If a payment is not made, your appointment may be subject to rescheduling to a later date.

PAYMENT OPTIONS

- Cash, Check, Visa, Mastercard, Discover, American Express:

We offer a 5% courtesy accounting adjustment to patients who pre-pay their entire treatment that is over \$1000 with cash, check, or credit card.

- CareCredit – with 12 months no interest

Patient, Parent or Guardian Signature

Date

Patient Name (print)

Date



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Appointments and Cancellation Policy

When we make your appointment, we are reserving time and a room for your treatment. There are many steps we take to prepare your appointment: a room is reserved for you, your records are prepared, special instruments are readied for you, and Dr. Chang is reviewing your individual needs for your procedure. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice, it delays the delivery of your dental care. We feel that our patient's time is valuable and try to accommodate with your personal schedule. We would appreciate this courtesy from you.

If you cannot make your appointment, please call our office immediately or give us a 48 hour notice.

Our staff will try their best to contact you thru the desired media.

I would like to be notified via: **TEXT** **EMAIL** **CALL** **USPS MAIL**

Phone Number

Email

More than 3 cancellations or missed appointments will result in loss of future appointment privileges and you may be dismissed from our office. This policy has been established to help us serve you better.

I have read and understand the cancellation policy. Should my plans change I will call the office to change my appointment.

Patient, Parent or Guardian Signature

Date

Patient Name (print)

Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If Yes, please name the members allowed and relation to you:

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Primary Dental Insurance:

Providing us with your dental insurance information allows us to verify your coverage and provide you with an estimate based on your plan's benefits. Please provide all accurate information in order for all claims to be properly billed to your insurance.

Subscribers Name: _____
Last First MI

Date of Birth: _____ ID#: _____ Group#: _____

Subscribers Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient Relationship to Subscriber: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code



SLEEP HEALTH QUESTIONNAIRE

PATIENT INFORMATION:

FULL NAME: _____ DATE OF BIRTH: _____ PHONE #: _____

AGE: _____ GENDER: _____ HEIGHT: _____ WEIGHT: _____

PLEASE CHECK ALL THAT APPLY FOR THE FOLLOWING QUESTION:

Have you been diagnosed or treated for any of the following conditions?

	Y	N		Y	N
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Nasal oxygen use	<input type="checkbox"/>	<input type="checkbox"/>
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sleep medication	<input type="checkbox"/>	<input type="checkbox"/>
Restless leg syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>

EPWORTH SLEEPINESS SCALE:

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation.(M.W. Johns, Sleep 1991)

	0	1	2	3
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FREQUENCY:

On average, in the past month, how often have you snored or been told that you snored?

NEVER RARELY SOMETIMES FREQUENTLY ALMOST ALWAYS

Do you wake up choking or gasping?

NEVER RARELY SOMETIMES FREQUENTLY ALMOST ALWAYS

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

NEVER RARELY SOMETIMES FREQUENTLY ALMOST ALWAYS

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

NEVER RARELY SOMETIMES FREQUENTLY ALMOST ALWAYS

SIGNATURE: _____

DATE: _____