



# FORT WORTH PEDIATRIC DENTISTRY

BRUCE H. WEINER, D.D.S. • JANELL I. PLOCHECK, D.D.S.

DIPLOMATES OF THE AMERICAN BOARD OF PEDIATRIC DENTISTRY

NATHAN G. WEST, D.M.D

## INSURANCE INFORMATION

Patient's name(s) \_\_\_\_\_

**PRIMARY DENTAL INSURANCE:** In order to file your insurance, **all** information **must** be provided.

Employee's Full Name: \_\_\_\_\_ Employee's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Insurance I.D. #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer City/State: \_\_\_\_\_

Address of Employee if different than patient: \_\_\_\_\_

### **SECOND DENTAL INSURANCE:**

Employee's Full Name: \_\_\_\_\_ Employee's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Insurance I.D. #: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer City/State: \_\_\_\_\_

Address of Employee if different than patient: \_\_\_\_\_

### **Assignment of Insurance Benefits**

In consideration of services rendered, I hereby transfer and assign to: Fort Worth Pediatric Dentistry  
6210 John Ryan Drive  
Fort Worth, Texas 76132

All rights, title and interest in any payment due me for services as provided in the policy or policies of insurance held by me.

I agree to pay, at Fort Worth, Tarrant County, Texas, the charges of Fort Worth Pediatric Dentistry which exceed the amount paid by the policies held by me.

I further agree and authorize the above named dentist to release any information requested by the insurance company(s) or its representatives.

The undersigned accepts full responsibility for the account.

Policy Holder or Authorized Agent: \_\_\_\_\_ Date: \_\_\_\_\_

Your dental insurance is your financial responsibility. Regardless of what is calculated as your dental benefit in dollars, we must stress the fact that you are responsible for the total cost of your dental treatment. As a courtesy to you, Fort Worth Pediatric Dentistry will file your insurance claims and ask that you pay an **estimated** portion based on typical dental insurance coverage at the time of service. You are responsible for any remaining balance after insurance has paid.



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## FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. **Payment for services is due at the time services are rendered.** We accept cash, checks, and credit cards (VISA, MasterCard, and Care Credit).
2. **New patient emergency visits must be paid in full at the time of the appointment.**  
As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for reimbursement or you may assign the payment to our office and we will file the primary insurance for you. **Secondary insurance will be filed only if the correct information is provided at the time of service.**
3. You must provide the office with correct **dental** insurance information at the time of the service to include the mailing address, phone and group number. If insurance coverage cannot be verified, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
4. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and estimated co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Any remaining balances will be billed to you after a claim is paid.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the type of plan purchased by your employer and is not related to our professional fees.
5. Blue Cross Blue Shield and many Delta Dental plans do not allow payment assignment to non-providers. We will file your BCBS and Delta insurance, however, **you will be required to pay in full at the time of service** if your plan is determined to be a non-assignment plan. BCBS and Delta will send payment directly to you.
6. Past due accounts will be notified via statement notes. If the account remains unpaid, we will be required to employ a collection service to collect payment. There is a **\$5.00 per month late fee for accounts over 60 days**. The responsible party agrees to pay all related collection fees. There is a **\$35.00 service charge for all returned checks**.
7. Our office will make every **reasonable** effort to obtain payment from your insurance company. If the claim remains unpaid after 120 days, you will be responsible for the remaining balance. Any additional insurance appeals will become your responsibility. We will be happy to provide you with any necessary forms or receipts.
8. **The parent or guardian who brings the child for an initial visit is the responsible party. This parent is required to pay for services rendered regardless of what a divorce decree may state.**

## AUTHORIZATION

1. I authorize Dr. Weiner, Dr. Plocheck, and staff to release any information concerning my case to my insurance company.
2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

\_\_\_\_\_  
Patient Name(s) (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Responsible Party

\_\_\_\_\_  
Print Name of Responsible Party



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## PATIENT HEALTH INFORMATION

The following information is requested to enable us to give the most consideration to your time and feelings. It is our sincere desire to give personal attention to each of our patients and parents.

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_

Nickname \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Does your child have a health problem? Yes  No

Does your child take any medicine(s) regularly? Yes  No

If yes, please list: \_\_\_\_\_

Has your child experienced any unfavorable reactions to any medicine(s)? Yes  No

Has your child ever been hospitalized or had any surgical procedures? Yes  No

When? \_\_\_\_\_

Reason? \_\_\_\_\_

Has your child had any history of the following or currently being treated for:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Cardiac Issues/Heart Murmur | <input type="checkbox"/> Epilepsy/Seizures      | <input type="checkbox"/> Lung Disease            |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Cleft lip or palate         | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Hearing Impairment     | <input type="checkbox"/> Speech Problems         |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Dyslexia                    | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Emotional Issues            | <input type="checkbox"/> Kidney/Liver Issues    |  |

Has your child been tested for or diagnosed with any neurological disorders? Yes  No

- |                                 |  |                              |   |
|---------------------------------|--|------------------------------|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> PDD | <input type="checkbox"/> Sensory Integration Disorder |
|---------------------------------|--|------------------------------|---|

Other: (Please list) \_\_\_\_\_

Please explain briefly why you brought your child for dental care: \_\_\_\_\_

Is this your child's first visit to the dentist? Yes  No

If no: Name of previous dentist \_\_\_\_\_ Date of last dental visit \_\_\_\_\_ Were x-rays taken? Yes  No

Has your child experienced any unfavorable reaction from any previous dental care? Yes  No

Does your child have a toothache now? Yes  No

Has your child had a toothache? Yes  No

Does your child use a pacifier or have a finger / thumb sucking habit? Yes  No

Does your child have a nursing bottle or sipper cup habit? Yes  No

### Consent for Treatment of a Minor

The undersigned hereby authorizes Fort Worth Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services using methods deemed appropriate for the care of the above-named child. This consent shall remain in full force and effect until cancelled by either party.

I understand that I am responsible for the full cost of necessary dental treatment for the above named child regardless of insurance coverage.

I understand that I am responsible for notifying this office of any accidents, major illnesses, or changes in medical history of the above named child.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Who is accompanying this child today? \_\_\_\_\_ Relationship to child \_\_\_\_\_

Do you have legal custody of this child? \_\_\_\_\_



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## PATIENT ACQUAINTANCE INFORMATION

DATE: \_\_\_\_\_

Child(ren)'s Name(s) \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

Child's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's Phone: \_\_\_\_\_ Child's School: \_\_\_\_\_

Mother's Information: ( ) Mother ( ) Stepmother ( ) Legal Guardian ( ) Other

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work Phone: \_\_\_\_\_ DL#: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Father's Information: ( ) Father ( ) Stepfather ( ) Legal Guardian ( ) Other

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work Phone: \_\_\_\_\_ DL#: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent's Dentist: \_\_\_\_\_ Child's Pediatrician: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person responsible for the account: \_\_\_\_\_

Do you have insurance? Yes \_\_\_\_\_ No \_\_\_\_\_



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## PARENT / PATIENT GUIDELINES

Thank you for choosing Fort Worth Pediatric Dentistry to help maintain your child's dental health. We will do our best to make your visits as pleasant and comfortable as possible. In order to maintain the highest standard of care for all of our patients, we have provided the following guidelines that we trust you will understand and accept.

1. **Food and Drink:** In compliance with OSHA standards for healthcare practices, no food or beverage is allowed in the office.
2. **Cell Phone Use:** In consideration of others, cell phone conversation is prohibited in the office.
3. **Late Arrivals:** We have reserved adequate time in our schedule for your child's appointment. Late arrivals will need to be rescheduled in order to maintain the high standards of care that our practice provides for our patients.
4. **Missed Appointments:** We make every effort to appoint our patients as expeditiously as possible. Appointments cancelled less than 24 hours in advance or no shows are considered as missed appointments which do not allow us to accommodate other patients in need. There will be a charge for repeated missed appointments or appointments cancelled without adequate notice.
5. **Photos/Video:** Photos and/or video are prohibited in the treatment area. We will be happy to take a photo of your child with the Dr. or a staff member if desired.
6. **Appointment times:** Children under the age of 6 will be appointed in the morning. Afternoon appointment times are reserved for age 6 and above.
7. **Payment:** Our office accepts cash, checks, Visa, Mastercard and Care Credit. Payment for any estimated patient portion is due in full at the time of service.
8. **Insurance:** As a courtesy, we will file your dental insurance. You must provide all necessary information including, employer name, claims address, group number, phone number and social security number. You will be expected to pay any estimated portion due at the time of service. Any amounts not paid by the insurance company as well as any denied claims are the responsibility of the patient. If you prefer not to provide the necessary information, you will be expected to pay in full at the time of service and will be given the necessary receipts for you to file your insurance.

**Note:** BCBS Federal Plan and many Delta Dental plans do not allow payment to non-providers. We will still file your claims for you, however, you will be required to pay in full at the time of service. Delta and BCBS will send payment directly to you.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

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FORT WORTH PEDIATRIC DENTISTRY, L.P.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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FORT WORTH PEDIATRIC DENTISTRY, L.P.

# NOTICE OF PRIVACY PRACTICES

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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

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## 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 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 04/14/03, 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.

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## 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 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 voicemail messages, postcards, or letters).

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## **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. 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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**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. The address for the U.S. Department of Health and Human Services is also listed below.

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: SHERRY H. REAVES

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Telephone: 817/292-5140 Fax: 817/292-3842

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E-mail: [info@fwpediatricdentistry.com](mailto:info@fwpediatricdentistry.com)

Address: 6210 JOHN RYAN DR. STE 100, FORT WORTH, TX 76132

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Region VI, Office for Civil Rights

U.S. Department of Health and Human Services

1301 Young Street, Suite 1169

Dallas, TX 75202

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## FORT WORTH PEDIATRIC DENTISTRY, L.P.

### HEALTH INFORMATION ACCESS

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The following names are of people, including myself, that I would like to be involved in or have access to my child's protected health information. I give permission for FORT WORTH PEDIATRIC DENTISTRY, L.P., to share my child's protected health information with:

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Name	Relationship	Social Security/or Drivers License
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Name	Relationship	Social Security/or Drivers License
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Name	Relationship	Social Security/or Drivers License
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Name	Relationship	Social Security/or Drivers License
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**Signature**

**Date**

If you wish to add or terminate information access to or from the above list, you must submit your request in writing to: Fort Worth Pediatric Dentistry, L.P.- Attn: Sherry  
6210 John Ryan Dr. Ste. 100  
Fort Worth, TX 76132

You may also fax your request to 817/292-3842. Please sign and date your request.