MINIMALLY INVASIVE DENTAL AESTHETICS
Kevin M Brown DDS

OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, American Express, personal check, money order, or registered check.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. Upon your request, we would be happy to submit a pre-determination to your insurance company prior to your treatment in addition to the cost estimate you will receive from our office. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance wallet card and 2) all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

We reserve the right to charge and collect fees for broken appointments – appointments that are cancelled or broken without 24-hours advance notice will receive a $75 fee. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of $40 will be added to your account balance and is collectible. Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.
Courtesies cannot be combined and are not to exceed 5%. I have read and understand this financial policy.

_____ _____

SIGNATURE PRINTED NAME

_____

DATE

425-454-7690
301 116th Ave SE, Suite 100
Bellevue, WA 98004
KevinMBrownDDS.COM

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Kevin M. Brown, Howard P. Jensen, and Brian Fong. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Kevin M. Brown, Howard P. Jensen, and Brian Fong reserve the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY ( ) YES ( ) NO
SPOUSE ONLY ( ) YES ( ) NO
OTHER (PLEASE SPECIFY)_____ ( ) YES ( ) NO

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED
PROVIDED PRIOR TO TREATMENT ( ) YES ( ) NO
DATE PROVIDED:_____
REASON FOR DENIAL: ☐NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES
☐WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING
☐UNABLE TO SIGN REASON NOT GIVEN
☐OTHER(EXPLAIN)_____
_____

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PATIENT INFORMATION

DATE | SS# | BIRTHDATE

NAME

LAST NAME | FIRST NAME | MIDDLE INITIAL

ADDRESS

CITY | STATE | ZIP

HOME PHONE | CELL PHONE | WORK PHONE

EMAIL ADDRESS

SEX: ☐ M ☐ F ☐ | SINGLE ☐ | MARRIED ☐

EMPLOYER | BUSINESS PHONE

BUSINESS ADDRESS | OCCUPATION

WHO SHOULD WE THANK FOR REFERRING YOU?

EMERGENCY CONTACT | PHONE

PRIMARY INSURANCE

RESPONSIBLE PARTY

LAST NAME | FIRST NAME | MIDDLE INITIAL

RELATIONSHIP TO PATIENT | BIRTHDATE | SS#

ADDRESS | HOME PHONE

CITY | STATE | ZIP

RESPONSIBLE PARTY EMPLOYER | BUSINESS PHONE

BUSINESS ADDRESS | OCCUPATION

INSURANCE COMPANY

INSURANCE COMPANY ADDRESS

SUBSCRIBER ID# | GROUP#

ADDITIONAL INSURANCE

INSURED NAME

LAST NAME | FIRST NAME | MIDDLE INITIAL

RELATIONSHIP TO PATIENT | BIRTHDATE | SS#

ADDRESS | HOME PHONE

CITY | STATE | ZIP

INSURED EMPLOYED BY | BUSINESS PHONE

BUSINESS ADDRESS | OCCUPATION

INSURANCE COMPANY

INSURANCE COMPANY ADDRESS

SUBSCRIBER ID# | GROUP#

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MEDICAL RECORD RELEASE

DATE:_____

Please release my dental records and send them to the office of Dr. Howard P. Jensen, Dr. Kevin M. Brown and Dr. Brian M. Fong to the address listed above or email to FRONTDESK@JENSENBROWNDDS.COM

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE#:_____

Other family members for which transfer is requested:

_____

_____

_____

_____

SIGNATURE DATE

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Digital Photography Informed Consent

I, _____, a patient of Dr. Kevin Brown, Dr. Howard Jensen and/or Dr. Brian Fong have consented to digital photography. I understand that photographs may be taken during my dental procedures to enhance laboratory communication and the final result of my treatment. I also give my consent for Drs. Brown, Jensen, and Fong to use photographs of my treatment for teaching and educational purposes. They may also use them in the office photo albums. website and/or social media. No names will be used when showing the photos.

Signature of patient or personal representative: _____ Date: _____

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MINIMALLY INVASIVE DENTAL AESTHETICS

Kevin M Brown

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Are you under a physician's care now? ☐Yes ☐No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No _____
Have you ever taken Fosamax, Boniva, Actonel or any _____
other medications containing bisphosphonates? ☐Yes ☐No If yes, please explain: _____
Are you on a special diet? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No

Women: Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐Yes ☐ No
Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Sulfa

Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Yes	☐No	Cortisone Medicine	☐Yes	☐No	Hemophilia	☐Yes	☐No	Radiation Treatments	☐Yes	☐No
Alzheimer's Disease	☐Yes	☐No	Diabetes	☐Yes	☐No	Hepatitis A	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No
Anaphylaxis	☐Yes	☐No	Drug Addiction	☐Yes	☐No	Hepatitis B or C	☐Yes	☐No	Renal Dialysis	☐Yes	☐No
Anemia	☐Yes	☐No	Easily Winded	☐Yes	☐No	Herpes	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Angina	☐Yes	☐No	Emphysema	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Rheumatism	☐Yes	☐No
Arthritis/Gout	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Excessive Bleeding	☐Yes	☐No	Hives or Rash	☐Yes	☐No	Shingles	☐Yes	☐No
Artificial Joint	☐Yes	☐No	Excessive Thirst	☐Yes	☐No	Hypoglycemia	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Asthma	☐Yes	☐No	Fainting Spells/Dizziness	☐Yes	☐No	Irregular Heartbeat	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Blood Disease	☐Yes	☐No	Frequent Cough	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Spina Bifida	☐Yes	☐No
Blood Transfusion	☐Yes	☐No	Frequent Diarrhea	☐Yes	☐No	Leukemia	☐Yes	☐No	Stomach/Intestinal Disease	☐Yes	☐No
Breathing Problem	☐Yes	☐No	Frequent Headaches	☐Yes	☐No	Liver Disease	☐Yes	☐No	Stroke	☐Yes	☐No
Bruise Easily	☐Yes	☐No	Genital Herpes	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Swelling of Limbs	☐Yes	☐No
Cancer	☐Yes	☐No	Glaucoma	☐Yes	☐No	Lung Disease	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Hay Fever	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tonsilitis	☐Yes	☐No
Chest Pains	☐Yes	☐No	Heart Attack/Failure	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Cold Sores/Fever Blisters	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Pain in Jaw Joints	☐Yes	☐No	Tumors or Growths	☐Yes	☐No
Congenital Heart Disorder	☐Yes	☐No	Heart Pace Maker	☐Yes	☐No	Parathyroid Disease	☐Yes	☐No	Ulcers	☐Yes	☐No
Convulsions	☐Yes	☐No	Heart Trouble/Disease	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Venereal Disease	☐Yes	☐No
									Yellow Jaundice	☐Yes	☐No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments:_____
_____

Do we have your permission to use email to confirm your appointments? ☐Yes ☐ No
If yes, please provide:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect

information can be
dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, email and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient of Dr. Howard P. Jensen and Dr. Kevin M. Brown. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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