Joseph E. Dotson D.D.S., P.A.

WHAT YOU CAN EXPECT FROM DR. DOTSON AND HIS TEAM

- **THOROUGH EVALUATION**: For us to help you attain a healthy mouth, we need to do a complete and comprehensive exam. This consists of checking your joints, muscles, gums, teeth and bite. We also evaluate your health history and how it impacts your oral health and study your previous dental work. We usually take a full set of radiographs (x-rays). With this information, Dr. Dotson will form a treatment plan customized for your health.

- **NOT ALL DENTAL WORK IS CREATED EQUAL**: It can be difficult to hear that the prior dental work in your mouth is failing. Whether it is due to excessive wear, time, or poor quality, the fact is that it may not last forever. Dr. Dotson's commitment and obligation to you is to tell you the way it is now, and what we can do to bring your mouth to perfect health.

- **TREATMENT PLAN**: We are dedicated to bringing your mouth to a state of health that you will be able to maintain for a lifetime. We will listen to you and form a personal treatment plan for you. This can include a plan for maintenance and a plan for restoration. Everything that Dr. Dotson recommends will be explained, and the decision as to how to proceed will be left up to you. Our Front Office staff will guide you through your treatment plan and answer your questions regarding financing, scheduling, and procedures.

- **HYGIENE**: Hygiene is the backbone of dental health. There is a constant battle going on in your mouth with the bacteria that live there. There are places in your mouth that you can't get to, and even the best home care is not enough. The most cost-effective way to keep your mouth healthy is to have regular professional cleanings. We have two dedicated and talented hygienists who will care for your professional hygiene needs and educate you regarding your home care.

- **TIME**: We understand the value of time. With our Front Office staffs' expertise in scheduling, your appointment will be reserved for the best time that works for you.

- **PAYMENT**: Fees are due at the time of service. If you have dental insurance, our Front Office staff are experts at helping you understand and maximize your insurance benefits. As a courtesy to you, we will file your insurance claims for you, and your insurance company will pay you, or Dr. Dotson, according to the terms of your policy. For major treatment, you may be asked to provide a down payment in order to reserve your appointment. We accept MasterCard, Visa, and Discover, as well as Debit, Cash, or Checks. Returned checks will be assessed service fees.

- **REFERRALS**: Dr. Dotson works closely with many talented local dental specialists. If you require a special procedure that Dr. Dotson feels would be best performed by a specialist, referral options will be discussed.

- **CELL PHONES**: In order to provide focused one on one care, we ask that you please turn off your cell phone. If you are expecting an important phone call, please turn your phone to vibrate, or ask for the assistance of a dental team member.

- **THANK YOU**: We appreciate you choosing us to care for your dental needs. Your referrals of friends, neighbors and family is one of the finest compliments that we can receive.

Joseph E. Dotson D.D.S., P.A.
5301 S. Dale Mabry Highway
Tapa, FL 33611
(813) 839-8140
www.drjosephdotson.com

Joseph E. Dotson D.D.S., P.A.

Office Hours

Monday-Thursday
8:00 a.m. – 5:00 p.m.
Closed Friday

FINANCIAL POLICY

On your first visit payment is due when services are rendered, payable by cash, check or credit card. Following your examination and consultation with Dr. Dotson, a written treatment plan will be presented for your major services, at which time we will discuss the treatment schedule and any financial arrangements at your request.

PATIENTS WITH INSURANCE

It is the patient's responsibility to provide the insurance form, complete with patient/employee information and properly signed. We will accept assignment of benefits, if you have signed that portion on your insurance form. If not, you will be expected to pay the full cost for all services when they are rendered.

Almost no dental insurance plan covers 100% of the cost of the treatment. Because of this, you will be asked to pay your deductible and estimated patient portion of your account when services are rendered.

It is very important for you to know that, if we have not received payment from your insurance company within 45 days of billing them, the balance becomes your responsibility. Law requires the insurance company to process claims in 45 days or less. The insurance agreement is between you and your insurance company, so you will be expected to deal with your insurance company directly should any problems arise. Our service agreement is with you, the patient, and not with the insurance company. We will assist you in completing the form and submit x-rays so you can obtain your benefits, but we cannot guarantee the benefits under your policy. Our office is only able to obtain a general breakdown of your benefits, but we cannot guarantee these benefits will be paid. Any questions regarding your coverage, deductibles, or reimbursements, should be directed to your employer or insurance carrier.

If there are any questions about whether your insurance company covers a procedure, or what percentage your insurance company will cover, or if you have enough of your yearly maximum to cover a procedure, please check with your insurance company. If you wish to proceed immediately with a procedure, then you (the patient) must be prepared to pay for that procedure, in full, when services are rendered.

PATIENTS WITHOUT INSURANCE

All our patients will be expected to pay the full cost for all services when they are rendered. Our office does not bill for services rendered. If you need alternative arrangements other than cash, check, or credit card, we have some financing options available. These arrangements would need to be made prior to your treatment. We will be happy to discuss this with you upon your request.

DUAL INSURANCE POLICY HOLDERS

All claims will be filed with your insurance company and the patient will be responsible for the balance. Our office policy is for our patients to pay their portion of what the primary insurer doesn't cover, at the time services are rendered. Our office never files to the secondary insurer. The patient may file with the secondary insurance company and the benefits will be directly reimbursed to the patient.

BROKEN APPOINTMENT POLICY

Our office is dedicated to keeping our fees as reasonable as possible. One of the costliest problems, in the dental industry, is broken appointment time. Since our office does not over-schedule, we reserve time, personnel, and facilities just for your scheduled appointment. If we do not have 24 hours notice of a change of the reserved time, we are unable to call another patient and use that time in a cost-effective manner. We will make every effort to extend to you a courtesy call reminding you of your appointment, but in the event we are unable to confirm before the 24-hour period, the responsibility for the appointment is the patient's. Please keep in mind that we are closed on Fridays so Thursday would be 24 hours notice for Monday appointments. If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned, we recover our lost opportunity and associated costs for having our Staff on standby with a Broken Appointment Fee of $50. Please understand that we strive to stay on time for your appointment as well as those patients that follow you. ***We really do not want to charge this fee so please give us 24 hours notice!!***

UNACCOMPANIED MINORS (UNDER 18 YEARS OF AGE)

We will be unable to treat children under the age of 18 unless a parent or guardian accompanies them. If circumstances are unavoidable and the parent is unable to attend the appointment with the child, then the appointment will need to be rescheduled.

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

It is the policy of this office to transfer the records of the patient to the new dentist. The original records will remain the property of Joseph E. Dotson DDS. Payment is required to cover the cost of duplication and/or copying patient records. Once payment is provided, the records will be duplicated within 3 days. If you request your full set of x-rays only, the charge for duplication is $45.00. If you request both your x-rays and treatment notes, the cost for duplication is $60.00. This payment must be provided before we can duplicate records.

OUTSTANDING BALANCES: The release of your dental records does not negate any outstanding balances on your account. You are still responsible for that balance and legal action will be pursued to collect that balance. You will be responsible for the balance as well as collection and legal costs associated with collecting the debt.

Dental Records Release Form

I, (print patient or guardian name) _____, hereby authorize the doctor and staff of Dr. Joseph E. Dotson DDS to release records or knowledge concerning my dental health to

Sent directly to a dental office:

Name of Dental Practice: _____

Address: _____

Telephone Number: _____

I am requesting that you release the following (check 1 or both):

1. _____ all x-rays 2. _____ all treatment notes

Please complete this form and bring it to our office. Please be aware that payment must be rendered before the records will be duplicated.

The fee is $45.00 for x-rays only and $60.00 for x-rays and treatment notes. Once the payment is applied to your account, please give us 3 business days to honor your request.

Joseph E. Dotson D.D.S., P.A.

Regardless of Insurance **Person Responsible For Account/Payments/Co-Pays**

The following information is for: _____Self

_____ Patient's Spouse _____ Parent/Guardian _____ (Other)

____ Male ____ Female Circle One: Married Single Separated Divorced Widowed

Social Security #: _____ Date of Birth _____

Phone #(s) Home: _____ Cell _____

Address: _____

City _____ State _____ Zip Code _____

Employer Name: _____

Work Phone _____

Employer Address: _____

City _____ State _____ Zip Code _____
Street

I have read the above conditions of payment and agree to their content.

_____ Date _____
Signature of Responsible Party/Guarantor of payment

Joseph E. Dotson D.D.S., P.A.

Patient Information

Date _____

(Please Print Complete Answers)

Last Name _____ First Name _____ MI _____

Sex M or F Please Circle One: Child Single Separated Married Divorced Widow

Social Security # _____Date of Birth _____ Age _____

Mailing Address:_____ City _____

State _____ Zip Code _____ Email _____

Home Phone _____ Cell Phone _____

Work Phone _____ Other _____

The preferred telephone number to reach me, listed from above, is:

☐ Cell # ☐ Home # ☐ Work # ☐ Other #

If you are filling this form out on behalf of another person, what is your relationship to person?

Name _____ Relationship _____

Reason for today's visit: _____

How did you hear about us? (circle one)

Social Media Internet Website Family/Friend Insurance Other

Who can we thank for your visit? _____

Consent for Services

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

You, the patient, are an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Please discuss the potential benefits, risks and complications or recommended treatment with your dentist. Be certain all your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

I have read the conditions of treatment and services stated above and agree to their content.

Signature of Patient or Parent/Legal Guardian (if a Minor) _____

Relationship to Patient: _____

PATIENT INFORMATION

Are you presently ill or under the care of a physician? _____Yes _____No
If yes, please describe:_____
History of Hospitalizations: _____

Please list any Allergies:_____

List all medications presently taking:_____

_____

*Regarding *Osteoporosis*:
*Are you presently taking medication to treat Osteoporosis? ___No ___Yes - How Long? _____
*If you have taken medication to treat Osteoporosis in the past, but stopped, how long did you take it?
_____
*What was the name of the medication? _____

Circle any Family History of: Heart Disease Cancer Diabetes Seizures
Your Social History: Tobacco use: (Type and Frequency of use) _____
Alcohol consumption: (Type and Frequency of use) _____

HAVE YOU EVER HAD, OR HAVE YOU NOW, ANY OF THE FOLLOWING: (Please check)

	Yes	No	Unsure		Yes	No	Unsure
AIDS/HTLV-III Positive	___	___	___	High Blood Pressure	___	___	___
Alcoholism	___	___	___	Hives	___	___	___
Anemia	___	___	___	Kidney Problems	___	___	___
Arthritis	___	___	___	Liver Disease	___	___	___
Asthma	___	___	___	Mitral Valve Prolapse	___	___	___
Blood Transfusion(s)	___	___	___	Nervousness	___	___	___
Bruise or Bleed Easily	___	___	___	Pacemaker	___	___	___
Cancer/Radiation Therapy	___	___	___	Painful Joints (incl. jaw)	___	___	___
Cold Sores (Herpes)	___	___	___	Persistent Cough	___	___	___
Congenital Heart Lesions	___	___	___	Prosthetic Heart Valve	___	___	___
Diabetes	___	___	___	Prosthetic Joint(s)	___	___	___
Drug Addiction	___	___	___	Rheumatic Fever	___	___	___
Emphysema	___	___	___	Sickle Cell Disease	___	___	___
Epilepsy or Seizures	___	___	___	Sinus Problems	___	___	___
Fainting or Dizziness	___	___	___	Steroid Medication(s)	___	___	___
Glaucoma	___	___	___	Stroke	___	___	___
Hay Fever	___	___	___	Thyroid Disease	___	___	___
Heart Murmur	___	___	___	Tuberculosis/PPD Positive	___	___	___
Heart Problems or Angina	___	___	___	Ulcers	___	___	___
Heart Surgery	___	___	___	Unexplained Weight Change	___	___	___
Hemophilia	___	___	___	Venereal Disease	___	___	___
Hepatitis – Type:	___	___	___	Yellow Jaundice	___	___	___

1.Do you have any disease, condition, or problem not listed above? If yes, please describe:
_____
2. Have you ever been told that you should not donate blood? _____Yes _____No
3. FEMALES: Are you taking birth control pills? _____Yes _____No
Are you or might you be pregnant? _____Yes* _____No *If yes, estimated delivery date: _____

_____ Date:_____
Signature of Patient or Parent/Legal Guardian (if a Minor)

Joseph E. Dotson D.D.S., P.A.

HIPAA CONSENT TO LEAVE MESSAGE

Patient Name _____

Regarding my care and follow-up:

I do _____ I do not _____ give my permission to leave relevant medical information on my Voice Mail and/or Email

I do _____ I do not _____ want relevant medical information shared with the person who may answer the telephone

The name (s) of the individual(s) with whom you may leave pertinent information is:

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Date _____

Signature of Patient or Parent/Legal Guardian (if a Minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

(see laminated copy of "Notice of Privacy Practice" on clip board)

You May Refuse To Sign This Acknowledgement

I, _____have read a copy of this office's Notice of Privacy Practices.

Print Name (Patient or Parent/Legal Guardian (if a minor)

_____ Date _____

Signature of Patient or Parent/Legal Guardian (if a minor)

For Office Use Only:

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

_____ Emergency Situation prevented us from obtaining acknowledgement

_____Other (please specify) _____