Orthodontic Associates
Smiling Faces, Beautiful Braces

Welcome to Our Office!

Thank you for selecting Orthodontic Associates for your orthodontic treatment needs!

Your first visit will involve a comprehensive orthodontic examination. If treatment is recommended, orthodontic records will need to be taken and we will have plenty of time to discuss the treatment plan, the estimated treatment time, and the fees associated with this service.

If you have insurance that covers orthodontic treatment, please make sure we have that information before the day of your examination so we can give you an estimated benefit during the appointment.

We have included some important forms with this letter. Please complete them ahead of time and bring them with you to your next appointment.

We are looking forward to a relaxed and pleasant visit with you. Please call or visit our website at www.shelbyncortho.com for directions or for more information about our practice. We will see you soon!

Sincerely yours,

The Doctor and Staff of Orthodontic Associates

Dr. Neal Patel, DMD, MS
1610 E. Marion St, Suite 200
Shelby, NC 28150
www.shelbyncortho.com
704-482-8934

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Information and Office Policy

Dental Care: Before braces are applied, we request you see your family dentist for a complete check-up, cleaning, and fluoride application. It is important to check for any cavities and have them taken care of before orthodontics. It is important to continue regular dental check-ups with your family dentist while wearing braces.

Scheduling Appointments: It is not possible to see all patients in the after-school/after-work hours. Therefore, it will be necessary to alternate appointments between these and morning hours. Complicated procedures requiring longer appointment times may need to be scheduled during morning hours. Proper adjustments of the appliances produce movement of the teeth for three to six weeks. More frequent appointments will not speed up the progress. Missed or cancelled appointments will result in a longer treatment time. If 3 or more consecutive appointments are missed, treatment may be stopped and appliances removed.

Gross lack of cooperation: In the event of gross lack of cooperation by the patient, the doctor reserves the right to discontinue treatment in order to prevent undue damage to teeth and supporting structure. Additional charges may be made for repair to damaged appliances, loose bands/brackets, or broken wires caused by improper patient care or abuse.

The Orthodontic Fee: The fee for treatment is determined by the severity of the problem and the difficulty of correction. As you would expect, this fee will vary from case to case. If you choose to proceed with treatment, you will be asked to sign a financial agreement and consent to treatment form. You will receive copies of both.

The payment schedule will ordinarily involve an initial payment, with the remaining balance to be handled in monthly payments. If paid directly to our office, no interest or late fees are involved unless accounts become delinquent.

Insurance Payments: A few insurance plans provide partial payment for orthodontic treatment. Our office will gladly assist you in filing claim forms. It should be remembered, however, that the financial agreement is between the doctor and the responsible party.

Delinquent Accounts
Should an account become delinquent, we encourage the responsible party to meet with the office financial consultant and arrange a mutually agreeable alternate payment schedule.

Late fee: a charge of $20.00 will be applied to the account if the monthly payment is not made before the 25th of the month due. Should the patient's account become 90 days past due (no payment in a 90 day period) normal adjustments will be suspended and appliances removed. The account can be paid to current status and treatment continued. The patient will be seen in the event of an emergency no matter what the status of the account.

As you can see, orthodontic treatment is a cooperative endeavor involving patient, parents, and orthodontist. It is our sincere desire that treatment be a beneficial & pleasant experience for everyone involved. We look forward to treating you and assure you that the doctor's best professional judgement and skills will be exercised.
Please keep this letter on file for future reference.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic date) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.)
- To third party payors or spouses (i.e., insurance companies, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payments, etc.)
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To other patients and third parties involving demonstration or scientific studies
- To your family and close friends involved in your treatment
- 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 or disclosures of your protected health information will be made only after obtaining our written authorization, which you have the right to revoke.

Under the new Privacy Rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information
- Request confidential communication of your protected health information
- Inspect and obtain copies of your protected health information through asking us
- Amend or modify your protected health information in certain circumstances
- Receive an accounting of certain disclosures made by us of your protected health information
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights (by submitting inquiries to our Privacy Contact person at our office) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation)

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our Privacy Notice that is currently in effect
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information
- Amend your protected health information if, for example, it is accurate and complete
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties

This Privacy Notice is effective as of July 5th, 2016.
If you have any questions about the information in this Notice, please ask for our Privacy Contact Person.

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ADULT WELCOME FORM

Date_____

Patient name _____ Preferred Name _____

Gender _____ Age _____ Birth date _____ Email _____

Address *(city, state, zip)* _____

Best number to be contacted at _____ ☐ Cell ☐ Home ☐ Other_____

Occupation _____ Employer _____

Whom may we thank for recommending our office to you? _____

Past or Present Family Members in Treatment _____

Have you consulted an orthodontist previously? _____

Marital Status: Married Separated Divorced Widowed Single

If married:

Spouse's name_____ Occupation _____ Employer_____

Best number to be contacted at _____ ☐ Cell ☐ Home ☐ Other_____

EMERGENCY Contact _____ Phone Number _____

Financial Information

☐ self

Financially Responsible Party _____ Relationship to patient _____

Address *(city, state, zip)* _____

Best number to be contacted at _____ Birth date _____

Occupation_____ Employer _____

Medical/Dental History

Physician _____ Physician Phone Number _____

Dentist _____ Date of last Dental cleaning _____

Past or current history of Smoking or Tobacco use? ☐ Yes ☐ No

See other side

Now or in the past, has the patient had:

Yes	No		Yes	No	
☐	☐	Abnormal bleeding/Hemophilia	☐	☐	Permanent teeth removed
☐	☐	ADD/ADHD	☐	☐	Supernumerary (extra) or congenitally missing teeth
☐	☐	AIDS/HIV+	☐	☐	Chipped or injured primary or permanent teeth
☐	☐	Artificial bones/joints/valves	☐	☐	Jaw fractures, cysts, infections
☐	☐	Asthma/Breathing Problems	☐	☐	Food impaction between the teeth
☐	☐	Bone/Joint Disorders	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc.)
☐	☐	Cancer/Chemotherapy/Radiation	☐	☐	Abnormal swallowing (tongue thrust)
☐	☐	Diabetes	☐	☐	Tooth grinding or clenching
☐	☐	Epilepsy	☐	☐	Clicking, locking, or soreness in jaw joints (TMJ)
☐	☐	Heart disease/murmur	☐	☐	Speech problems
☐	☐	Hepatitis	☐	☐	Difficulty chewing
☐	☐	Tuberculosis	☐	☐	Severe head or face injuries

Please explain any items checked 'yes' above _____

_____

_____

_____

Please list any other relevant medical conditions:

_____

Patient taking any medications? Y N If yes, please list:

_____

_____

I, the undersigned, have given the above information and certify that it is accurate. I have also received a copy of the Notice of Privacy Practices for Orthodontic Associates.

Signature _____ Date _____

I authorize the release of medical, dental, and/or financial information to the following:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

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