Financial Terms

Thank you for choosing Khanna Dentistry as your dental healthcare provider. We are dedicated to providing the highest quality of care possible. We are also committed to providing our patients clear and straightforward information regarding their financial responsibilities. The following is a statement of our Financial Terms that we require you to read and sign before treatment.

Patients without Insurance Coverage: Full payment is due at the time of service unless alternative financial arrangements have been made with Khanna Dentistry in advance and in writing. For your convenience, we accept cash, personal checks and all major credit cards.

Insurance Patients: Dr. Khanna does not participate in preferred provider programs. Payment will be expected in full at the time of service and the insurance company will reimburse you directly. As a courtesy to you, we will submit all insurance claims and supporting documents to your insurance company. Please remember, it is still your responsibility to alert us of any changes in your insurance coverage. Please bring your insurance card and all pertinent information that will allow us to determine the benefits available to you or if there has been any changes in your benefits.

Returned Checks: Patients whose checks are returned from the bank due to non-sufficient funds will incur an additional fee of $35.00.

Past Due Accounts: Past due accounts are referred to a collection agency. A collection fee ranging from $25 to up to 35% of all the balance due may be added to your unpaid balance to recover costs of collections. You will also be responsible for any and all attorneys’ fees, court costs and any other fees associated with the collection of your debt.

Extended Payment Plans: All extended payment plans are done through Care Credit, which is a third party financing company. They offer a wide variety of payment options including some interest-free payment plans. If you have any questions about applying for a Care Credit account, please speak with our Treatment Coordinator.

Broken or Missed Appointments: An appointment is considered broken if it is not kept or if it is changed with less than 24 hours noticed to us. Broken and missed appointments prevent other patients from receiving the dental care they require. Our practice takes all of our patients and their appointments seriously, so please be considerate and inform us at least 24 hours in advance if you need to change your appointment.

Fee for Missed Appointment if 24-Hour Notice is Not Given: To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of $45.00.

If you have any questions regarding your account, please contact our office at 630-845-1088. Thank you for understanding and accepting our financial policy.

I have read and agree to the terms of this Financial Term:

_______________________________________________________________________________________
Signature of Responsible Party                                     Print Name                                     Date
Patient Information

Patient Name: ___________________________________________ Nickname __________________

Last                      First                      Middle Initial

Patient Birthday: ______/_____/______ Patient Gender: M____ F____ Patient Social Security No. ___________ - ___________ - ___________

Patient Address:

Street                   City                   State                   Zip Code

Home Phone: (____)_________________________ Cell / Business Phone: (____)_________________________

Email: ____________________________

Reason for Visit: _______________________________________________________________________

Who may we thank for referring you? _______________________________________________________________________

Preferred Appointment Time (circle all that apply)  AM  PM  Available on Short Notice

Responsible Party Information

Responsible Party Name: _________________________________________________________________

Last                      First                      Middle Initial

Birthday: ______/_____/______ Social Security No. ___________ - ___________ - ___________ Relation to Patient: _______________________

Address: ____________________________________________________________

Street                   City                   State                   Zip Code

Home Phone: (____)_________________________ Cell / Business Phone: (____)_________________________

Email: ____________________________

Employer: ____________________________ Occupation: ____________________________

Number of years employed: ______

Consent

The undersigned hereby authorizes Dr. Khanna to take X-ray, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Khanna to make a thorough diagnosis of the patient’s dental needs. I also authorize Dr. Khanna to perform any and all forms of treatment, medication, and/or therapy that may be indicated. I also understand the use of an anesthetic agent embodies a certain risk.

I understand that payment is due in full at the time of service unless alternative financial arrangements have been made with Khanna Dentistry in advance in writing. I understand that late fee will be added to any over-due balances.

I understand that where appropriate, credit reports may be obtained.

Patient/Responsible Party Signature: ____________________________ Date: ______________

Dentist Signature: ____________________________ Date: ______________
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Birth Date:</th>
<th>Date Created:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you under a physician’s care now?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Have you ever been hospitalized or had a major operation?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Have you ever had a serious head or neck injury?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Are you taking any medications, pills, or drugs?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Do you take, or have you taken, Phen-Fen or Redux?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Are you on a special diet?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
<tr>
<td>Do you use tobacco?</td>
<td>Yes</td>
<td>If yes</td>
</tr>
</tbody>
</table>

**Women: Are you...**
- [ ] Pregnant/Trying to get pregnant?  
- [ ] Nursing?  
- [ ] Taking oral contraceptives?

**Are you allergic to any of the following?**
- [ ] Aspirin  
- [ ] Penicillin  
- [ ] Metal  
- [ ] Latex  
- [ ] Codeine  
- [ ] Sulfas  
- [ ] Acrylic  
- [ ] Local Anesthetics

**Do you use controlled substances?**
- [ ] Yes  
- [ ] No  
  If yes [ ]

**Do you have, or have you had, any of the following?**
- [ ] AIDS/HIV Positive  
- [ ] Alzheimer’s Disease  
- [ ] Anaphylaxis  
- [ ] Anemia  
- [ ] Angina  
- [ ] Arthritis/Gout  
- [ ] Artificial Heart Valve  
- [ ] Artificial Joint  
- [ ] Asthma  
- [ ] Blood Disease  
- [ ] Blood Transfusion  
- [ ] Breathing Problems  
- [ ] Bruise Easily  
- [ ] Cancer  
- [ ] Chemotherapy  
- [ ] Chest Pains  
- [ ] Cold Sore/Fever Blister  
- [ ] Congenital Heart Disorder  
- [ ] Convulsions  
- [ ] Yellow Jaundice  
- [ ] Hemophilia  
- [ ] Hepatitis A  
- [ ] Hepatitis B or C  
- [ ] Herpes  
- [ ] High Blood Pressure  
- [ ] High Cholesterol  
- [ ] HIV/Ca  
- [ ] Hypoglycemia  
- [ ] Irregular Heartbeat  
- [ ] Kidney Problems  
- [ ] Leukemia  
- [ ] Liver Disease  
- [ ] Low Blood Pressure  
- [ ] Lung Disease  
- [ ] Mitral Valve Prolapse  
- [ ] Osteoporosis  
- [ ] Pain in Jaw Joints  
- [ ] Parathyroid Disease  
- [ ] Psychiatric Care  
- [ ] Radiation Treatments  
- [ ] Recent Weight Loss  
- [ ] Renal Dialysis  
- [ ] Rheumatic Fever  
- [ ] Rheumatism  
- [ ] Scarlet Fever  
- [ ] Shingles  
- [ ] Sickle Cell Disease  
- [ ] Sinus Trouble  
- [ ] Spina Bifida  
- [ ] Stomach/Intestinal Disease  
- [ ] Stroke  
- [ ] Swelling of Limbs  
- [ ] Thyroid Disease  
- [ ] Tonsillitis  
- [ ] Tuberculosis  
- [ ] Tumors or Growths  
- [ ] Ulcers  
- [ ] Venereal Disease

Have you ever had any serious illness not listed  
- [ ] Yes  
- [ ] No  
  If yes [ ]

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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PERSONAL DENTAL NEEDS SURVEY

Name: _________________________ Date: ______________________

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care.
(1 = most important)

| ____Preventative Dental Health Care | ____Freedom from pain | ____Other |
| ____Excellence and quality of Service | ____Cost and Affordability |

Please rate on a scale of 1-3 what a dentist must do to gain your confidence.

| ____Show me what he/she is doing or needs to do so I can clearly understand what is happening. |
| ____Listen to my concerns and explain thoroughly the procedures to be performed. |
| ____Make sure I feel comfortable and informed at all times. |

Please circle the level of fear you have about your dental visits (10 being the greatest fear)

1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit. Check all that apply.

| ____Music or Movie with headphones (Please list your preferred music type) |
| ____Nitrous Oxide |
| ____Patient Education Material |
| ____Blanket |

___ Nitrous Oxide
___ Sedative Medications (oral and/or I.V.)
___ Neck Wraps
___ Other

Are you concerned about the following? (Mark Y-yes or N-no)

| ____Exiting Discomfort |
| ____Replacing old silver fillings |
| ____Recurring or untreated gum disease |
| ____Mouth order |

| ____Whitening your teeth |
| ____Appearance of my smile |
| ____Prevention of decay |

___ Whiten your teeth
___ Appearance of my smile
___ Prevention of decay
___ Other

Please check one answer for each of the following:

When discussing my treatment plan, I prefer:

| ____The big picture |
| ____Detail by detail |

When evaluating my smile, it is more important:

| ____What I see |
| ____What others see |

___What I see
___What others see
PHOTO RELEASE FORM

Neeraj Khanna DDS
Khanna Dentistry, P.C.
425 Hamilton St
Geneva, IL 60134

Permission to Use Photographs

Subject: Dental Photography

I grant Dr. Neeraj Khanna DDS, its representatives, and team members the right to take photographs of me, my mouth and teeth in connection with the above-identified subject. I authorize Dr. Neeraj Khanna, its assigns, and transferees to copyright, use, and publish the same in print and/or electronically.

I agree that Dr. Neeraj Khanna DDS may use such photographs of me with my name for any lawful purpose; including for example, such purpose as educational lecturing, illustration, advertising, and Web content.

I have read and understand the above:

Signature ________________________________

Printed Name ______________________________

Signature, parent or guardian (if under 18) ________________________________

Witness: ________________________________
TMJ History

Have you ever had or been diagnosed with a problem with either Jaw Joint?

Does your jaw click, pop or make noise when you open and close?

Do you ever have pain or tenderness in your jaw joint when you open, close or chew?

Has your jaw ever locked open or closed?

Do you have frequent headaches? If so, how often?

Do you clench or grind your teeth, or ever been told that you do?

Have you ever had trauma to your chin or jaw?
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ________________________________________________________________________________
Address: ________________________________________________________________________________
Phone: ____________________________________ Email: ________________________________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment, activities and healthcare operations of the uses and disclosures we may make of your protected health information and other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Office Coordinator/Practice Manager
Phone: 630-845-1088    Fax: 630-845-1088
Address: 425 Hamilton Street, Geneva, IL 60134

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent Form I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.

Signature: ___________________________________________ Date: _____________________
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: ______________________________________________________
Relationship to Patient: __________________________________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient’s chart.

Acknowledgement of Receipt of Privacy Practices
**You may refuse to sign this Acknowledgement**

I, ________________________________, have received a copy of this office’s Notice of Privacy Practices.
Name: ___________________________ Signature: ___________________________ Date: ________

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
______ Communication barriers prohibited obtaining the acknowledgement
______ An emergency situation prevented us from obtaining acknowledgement
______ Other _Please specify________________________________________

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association. This form is education only, does not constitute legal advice and covers only federal, not state law (August 14, 2002)

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternate means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.
Please indicate your request regarding our communication of Protected Health information to you:

___ Please do not call my home telephone with confidential information
___ Please do not call my work telephone with confidential information
___ Please do not leave a message on my telephone answering machine
___ If telephone call is required, please call: ____________________________
___ Please do not send confidential communications to my home address
___ Please do not send confidential communications to my work address
___ Please use this address to send confidential communications ________________________________
___ Other (Please explain)_______________________________________________________________

Print Name: ___________________________ Signature: ___________________________ Date: ______

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NOTICE OF PRIVACY PRACTICES

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.

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 April 14th, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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.

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).

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 practically 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 $0.10 for each page, $5 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.

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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. 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: Office Coordinator/ Practice Manager
Telephone: 630 845 1088    Fax: 630 845 1808

Address: 425 Hamilton Street, Geneva, IL 60134

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FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL BENEFITS

Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40%-80% range. Some plans base the amount of benefit on the schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage that the reimbursement level indicated in your dental plan.

For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by a dental office, ours or otherwise. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with or denying treatment.

We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission and submitting pre-determinations). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your potential portion of the charges. Thank you for understanding!
REGARDING APPOINTMENTS

Our time is valuable and so is yours. Our commitment to you is:

- We always try to make appointments that are convenient for you.
- We will not ask you to make a schedule change unless it is an extreme emergency or of a potential benefit to you.
- We will always be respectful of your personal time and will make every effort to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that we reserve chair time just for you when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved time as it is scheduled. Please give our office 48 hours (or more, if possible with the exception of extreme personal emergency) notice if you need to change your appointment or a fee will be assessed to your account based on the amount of time scheduled, at the rate of $100 per hour.

Please keep us informed of any changes to your health information and medications as well as your address, phone, email or insurance information so that we may service you in the best possible manor.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X ___________________________ ___________________________
(Patient or Parent or Guardian signature) (Date)

X ___________________________
(Print patient’s name)