Dr. Diana L. Galvis DDS, PC
Family Dentistry
142 Totowa Road, Suite 7
Totowa, NJ 07512

Patient Information

Date: _____

□ **Female** □ **Male**

Name: _____
(first) (last) (M.I.)

Address: _____
(street) (city) (state) (zip)

Social Security #: _____ **Birthdate**: _____

Telephone #: _____ _____ _____
(home) (work) (cellular)

Company Name and/or Name of Employer: _____

Medical Doctor: _____
(name) (address) (telephone #)

Primary Dental Insurance: _____

Secondary Dental Insurance: _____

Primary Dental Insurance Subscriber Information	**Secondary Dental Insurance Subscriber Information**
Name: _____	Name: _____
Birthdate: _____	Birthdate: _____
Social Sec. #: _____	Social Sec. #: _____
Tel. #: _____ _____ (home) (other)	Tel. #: _____ _____ (home) (other)
Employer: _____	Employer: _____

Has any member of your family ever been treated in our office? □ Yes □ No

Whom may we thank for referring you to this office? _____

Person to Contact in Case of an Emergency

Name:_____

Address: _____

City: _____

State / Zip: _____

Telephone #: _____

Full Payment is expected the day services are rendered.

Person Responsible For Account

□ Patient □ Guardian

□ Father or Husband □ Mother or wife

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and the other information about my dental treatment to third party payers and/or other health professionals. If there is any change in my insurance coverage, I understand that I am responsible for any unpaid balance by the insurance company.

Relationship:

□ Patient □ Guardian

□ Father or Husband □ Mother or wife

Signature:_____

Date: _____

Service Charge

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

□ I wish to discuss the Dental Office's Financial Policy

CANCELLATION POLICY

This office reserves the right to dismiss you as a patient if 24 hours notice is not given for appointment cancellation on any given three visits.

Dr. Diana L. Galvis, DDS PC

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this Acknowledgment Form *

**** If signing for a minor,*** Print Patient Name*:* _____

I _____ ,
(print patient name or ****if minor, print legal guardian name***)

understand that the *Notice of Privacy Practices* is available upon request. In addition, the *Notice of Privacy Practices* may be reviewed at www.DianaGalvisDDS.com.

****If signing for a minor***, please indicate your relationship to the patient here: _____

_____
(patient signature or ****if minor, legal guardian signature***)

_____
(date)

Please list the names of those persons we may share your health information with;
NOTE: Legal Guardians and Physicians do not need to be listed

Name	Relationship to Patient

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Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Dr. Diana L. Galvis, DDS, PC to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Dr. Diana L. Galvis, DDS, PC health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Dr. Diana L. Galvis, DDS, PC may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- Dr. Diana L. Galvis, DDS, PC does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Dr. Diana L. Galvis, DDS, PC already sent before receiving my written instructions to stop.

Patient name (please print): _____

Signature: _____ Date: _____

Email: _____

Dr. Diana L. Galvis, DDS, PC
142 Totowa Road, Suite 7
Totowa, NJ 07512
(973) 930-5733

Cancellation and Missed Appointment Policy

1. Cancellation and No-Show Policy for Dental Appointments:

Your dental health matters to us, and when you schedule an appointment, we allocate time with our Doctors, Hygienists, and Dental Assistants to serve you. Just as we aim to be punctual for your appointments, we kindly request the same consideration from you.

We recognize that emergencies or work and family commitments can arise, leading to missed appointments. However, failing to cancel an appointment without notice could prevent another patient from receiving necessary treatment. Likewise, if another patient misses their appointment, it may affect our ability to accommodate you.

To facilitate efficient scheduling, we ask for a minimum of **24 hours' notice** for cancellations or appointment changes. For appointments scheduled on a Monday, kindly notify us by 1:00 pm on the preceding Friday to avoid incurring a cancellation fee.

Cancellation fees for appointments cancelled with less than 24 hours' notice are as follows:	
Exam/Cleaning/Follow-Up/Consultation	$75
Basic Dental Treatment	$150
Dental Surgery/Comprehensive Dental Treatment	$250

These fees are the responsibility of the patient and must be paid in full before the next appointment. Please note that insurance does not cover these fees.

2. No-Show Policy:

Patients who fail to show up for appointments without prior notification or arrive 15 minutes or more late will be considered as "no-shows." If a patient accumulates two or more no-show incidents within a 12-month period, they will be required to prepay for all future dental appointments. Cancellation fees will still apply.

At our practice, we believe in clear communication and understanding to nurture a positive doctor/patient relationship. If you have any questions regarding our cancellation/missed appointment policy, please reach out to our patient coordinators.

Please acknowledge that you have read, understood, and agree to this Cancellation/Missed Appointment Policy:

Patient Name: _____

Name of Person Signing (if Minor): _____

Patient/Patient Representative Signature: _____

Date: _____