

Pomerance

INTEGRATIVE DENTAL CARE

EPWORTH SLEEPINESS SCALE

Name _____ DOB _____

Date _____ Gender _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

It is important that you answer each question as best as you can.

Situation

Chance of dozing (out of 3)

Sitting and reading

Watching TV

Sitting, inactive in a public place (eg. a theatre or a meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after a lunch without alcohol

In a car, while stopped for a few minutes in traffic

Total out of 24

Score Interpretation:

(1-10) Normal Range

(10-16) Excessively sleepy

(16-24) Abnormally sleepy



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INTEGRATIVE DENTAL CARE

Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is the patient's responsibility to provide the correct insurance information at each visit. As a courtesy to you, we will file your dental insurance via electronic claims.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. Any balance is your responsibility whether or not your insurance company pays any portion.

FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service.

We accept the following forms of payment: **Cash, Check, Visa, Discover, MasterCard, AmEx.**

Pre-payment with Cash or check discount: We offer a 5% accounting courtesy for all services that are paid in full *at the time of scheduling the appointment.*

We have also made arrangements with the Care Credit Company to provide payment plans. This allows you to complete your dental work without delay and make relatively small monthly payments. Applications are available and approval can be determined within ten minutes. For your convenience you can also apply online at www.carecredit.com

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Signature: _____ Date: _____

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for your disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature

Patient Name (please print)

I am also signing for my minor children: _____
(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature

Patient Name (please print)

I am also signing for my minor children: _____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

(please print names)

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

Office Personnel (signature)

Office Personnel (print name)

Date: _____



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Dear Patients,

Our no-show/cancelation policy is as follows:

A cancelation or a no-show is documented in the event that the patient cancels or no-shows **without giving us two business days notice of their scheduled appointment.** Our office no-show cancelation fee is seventy five (\$75.00) per hour.

We truly value our patient's time, just as we hope you value ours. Having said that, whenever a patient does not appear for a scheduled appointment, everyone is affected. You do not get the treatment needed and another patient loses out on the time that was allowed for you.

Please make every effort to provide to at least two business days notice if an appointment must be missed. We understand unexpected conflicts can occurs and that your lives are as busy as ours. We strive to work together with you to fit your schedule.

Thank you in advance for your understanding and cooperation,

Sheryl Pomerance, DDS & Staff

Agreed to and Acknowledged by:

Patient Name:

Patient Signature:

Date:
