Triad Adult & Pediatric Medicine
DENTAL

231 Plaza Ln. 2nd Floor High Point, NC 27263
Phone: 336-579-5555

New Patient Information Packet

TAPM is a federally funded community health center. TAPM is required to collect information on all patients' annual incomes. Please circle in the chart below the number of persons living within your home (household) and your annual income range. This information must be updated annually by all TAPM patients.

This information is used for internal purposes only and will not be disclosed to external sources/agencies/organizations.

2025 Federal Poverty Guidelines						
YEARLY INCOME						
Poverty Level Percentage						
Poverty Level % Ranges	**0%-100%**	**100% - 125%**	**126% - 150%**	**151% - 175%**	**176% - 200%**	**Over 200%**
1	≤$15,650	$15,651-$19,563	$19,564-$23,475	$23,476-$27,388	$27,389-$31,300	≥$31,301
2	≤$21,150	$21,151-$26,438	$26,439-$31,725	$31,726-$37,013	$37,014-$42,300	≥$42,301
3	≤$26,650	$26,651-$33,313	$33,314-$39,975	$39,976-$46,638	$46,639-$53,300	≥$53,301
4	≤$32,150	$32,151-$40,188	$40,189-$48,225	$48,226-$56,263	$56,264-$64,300	≥$64,301
5	≤$37,650	$37,651-$47,063	$47,064-$56,475	$56,476-$65,888	$65,889-$75,300	≥$75,301
6	≤$43,150	$43,151-$53,938	$53,939-$64,725	$64,726-$75,513	$75,514-$86,300	≥$86,301
7	≤$48,650	$48,651-$60,813	$60,814-$72,975	$72,976-$85,138	$85,139-$97,300	≥$97,301
8	≤$54,150	$54,151-$67,688	$67,689-$81,225	$81,226-$94,763	$94,764-$108,300	≥$108,301

The sliding fee scale below is for all medical, behavioral and nutritional services offered by TAPM.

% of charges	20% of charges	40% of charges	50% of charges	60% of charges	80% of charges	Patient pays the full amount of the bill NO DISCOUNT
Poverty Level % Ranges	0%-100% FPG	100%-125%	126%-150%	151%-175%	176%-200%	>200%

For family units with more than 8 members, add $5,500 for each additional member.** ***Source: https://aspe.hhs.gov/poverty-guidelines

Patient/Responsible party's name and signature

Last Name: _____ **First:** _____ **M.I.** _____

Signature: _____

Date: _____ **Medical Record Number:** _____

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Patient Information

Last Name:_____ **First:**_____ **M.I.** _____

Date of Birth:_____ **Sex:** ☐Male ☐Female **Social Security#:**_____

Race: ☐Black/African American ☐American Indian ☐Asian ☐Caucasian ☐Pacific Islander/Native Hawaiian ☐Other

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino **Language Spoken:** ☐English ☐Spanish ☐Other:_____
If Other, do you need an interpreter? ☐Yes ☐No

Patient's Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Patients Driver's License Number: _____ **Religion:** _____

Patient's Military Status: ☐Active ☐Retired ☐Veteran

Patient's Employment: ☐Full-time ☐Part-time ☐Self-employed ☐Unemployed ☐Disabled ☐Retired

Patient's Place of Employment: _____

For agricultural workers, are you: ☐Migrant ☐Seasonal ☐Employed Year-Round ☐Retired Farmworker

Preferred Pharmacy: _____

Patient's Street Address: _____ Zip: _____

Home phone number:_____ **Okay to call?** ☐Y ☐N **Okay to leave message?** ☐Y ☐N

Cell phone number:_____ **Okay to call?** ☐Y ☐N **Okay to leave message?** ☐Y ☐N

Work phone number:_____ **Okay to call?** ☐Y ☐N **Okay to leave message?** ☐Y ☐N

Email address:_____ **Okay to email?** ☐Y ☐N

How do you prefer we contact you? ☐Home Phone ☐Cell Phone ☐Work Phone ☐Text ☐Email ☐Other:_____

Do you live in public housing? ☐Yes ☐No -- If yes: ☐Family tenant ☐Senior housing ☐Section 8 ☐Vicinity of Section 8

Are you homeless? ☐Yes ☐No If yes: Approximately what date did you become homeless? _____ Which of the following best describes where you are staying? ☐Doubling up ☐Shelter ☐Transitional housing ☐Street/Vehicle ☐Other

Patient's emergency contact, Name: _____ **Phone:** ( ) _____

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Parent or Person Responsible for Bill (complete only if different from above)

Last Name:_____ **First:**_____ **M.I.** _____

Date of Birth:_____ **Sex:** ☐Male ☐Female **Social Security#:**_____

Street Address:_____ **Zip:**_____

Parent's Military Status: ☐Active ☐Retired ☐Veteran

Parent's Employment: ☐Full-time ☐Part-time ☐Self-employed ☐Unemployed ☐Disabled ☐Retired

Parent's Place of Employment: _____

For agricultural workers, are you: ☐Migrant ☐Seasonal ☐Employed Year-Round ☐Retired Farmworker

Insurance Information

Please indicate which of the following applies to you/your child:

☐The patient is enrolled in the Triad Adult and Pediatric Medicine, Inc. sliding fee scale
☐ The patient is enrolled in the Guilford Community Care Network (has an orange card)

☐The patient has Medicaid/NC Health Choice; ID Number_____ ☐

The patient has the following private insurance coverage:

Type of Insurance _____ Co-pay Amount $_____

Policyholder's Employer_____Address_____

Policyholder's Name _____Group #_____Subscriber ID # _____

Patient's relationship to the insured? ☐Self ☐Child ☐Special Dependent ● Is a copy of card available? ☐Yes ☐No

This medical practice works with its patients to make paying for services easier. When you come in for your appointment, you will be asked to pay any unmet deductible amounts and/or co-payments, which your insurance company allows to be collected. We will file claims with your insurance company, so please make sure that insurance information is correct. Anything not covered by insurance will be the parent's/patient's responsibility.

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Consent for Services ***Please complete the section below only if you are the parent/legal guardian of the patient****

As parent/legal guardian of patient named above, I understand my child cannot receive care at Triad Adult and Pediatric Medicine ('TAPM') with a non-guardian adult unless I have given written permission for this adult to bring my child. This permission also includes authorization for my child to receive immunizations during a visit with the adults listed below.

I authorize the following adults to bring my child for care in my absence:

Name of Individual	Relationship to Child	Phone Number

I also understand that I must bring my child for their first visit at TAPM to ensure an accurate medical history is given. I also agree for future visits to be available by telephone if not in person. The person who brings my child must also have a full understanding of the illness my child is coming in for. This person should also know other medical conditions and/or allergies my child has. I have the right to review TAPM's Notice of Privacy Practices before signing this consent form. I also understand that TAPM uses an automated telephone reminder system, and that calls will be made to my home or the home of one of the persons listed above when my child has a scheduled appointment.

Parent/Legal Guardian Signature: _____ Date Signed: _____

TAPM Dental Staff Witness Signature: _____ Date Signed: _____

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TAPM COMBINED CONSENT & PATIENT AGREEMENT

Triad Adult and Pediatric Medicine is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business associate of **Triad Adult and Pediatric Medicine** OCHIN supplies information technology and related services **Triad Adult and Pediatric Medicine** and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by **Triad Adult and Pediatric Medicine** with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent; however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Section 1: Permission to Share Protected Health Information

HIPAA (Health Insurance Portability & Accountability Act of 1996) establishes guidelines to specifically protect your privacy by restricting information (oral, recorded, on paper, or sent electronically) about a patient's physical or mental/behavioral health, services given or payment for those services, and personal information connecting the patient to the records. To provide efficient, quality, patient-friendly medical care while ensuring patient privacy, we require permission for methods of contact that we may use for your Protected Health Information.

I give my permission for Triad Adult and Pediatric Medicine, its physicians and employees to contact and leave detailed messages specific to my/my child's medical care, including test results, on the phone number(s) I have provided. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access. This permission begins as of the date signed below and will remain in effect until cancelled in writing by the patient/guardian. I understand that such revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

Section 2: Permission to Release Information

Your signature gives our organization permission to release all information regarding the patient's treatment, including information about behavioral health, to his/her insurance company/companies and to any other health care provider to which the patient may be referred. Also, signing this form gives permission to treatment and/or care management by the provider/practice and any other agency or person associated with the provider/practice involved with the patient's care and wellbeing.

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Section 3: Promise to Pay Account

For all services given by Triad Adult and Pediatric medicine, the patient or any responsible party that signs below agrees to pay all charges for the patient's account. I/we understand that I/we will be responsible for all charges not covered by private insurance, Medicare, Medicaid, indigent care program or any other federal, state or county agency. If I/we fail to pay any charges within thirty (30) days from date of service, I/we will be in default. If I/we default and an attorney is needed for collection, I/we agree to pay the attorney's fee of fifteen percent (15%) of the balance due. I/we will also pay any costs and other expenses gained in the collection of this account. Triad Adult and Pediatric Medicine may access my payment predictor score through Search America and/or my credit report to decide if I qualify for Financial Assistance.

Section 4: Specialty Services Consent

Triad Adult and Pediatric Medicine, Inc. is an integrated, primary care medical home. This means that in addition to being a medical office that offers you primary care services, you agree as a part of our practice to receive additional on-site specialty care services through and recommended by the integrated health care team. Your integrated health care team could consist of a medical provider, nurse, certified medical assistant, specialty clinicians, and community liaison. Specialty care services may include screening, assessment and treatment in the following areas: Asthma, Behavioral Health, Developmental, Nephrology, Neurology, Nutrition/Dietetics, Podiatry, Psychiatry and/or other healthcare personnel in training. Specialty services are subject to change based on availability or access to specialty providers. Mental Health and Substance Use services may be subject to different confidentiality rules based on state and federal guidelines. Any patient can decline specialty services by informing a provider. The patient understands and acknowledges that no guarantee or assurance has been made as to the results that may be obtained from the specialty services. Specialty services may not be covered by your insurance and may result in the cost of the services being the patient's responsibility.

Section 5: Our Policies

We are dedicated to serving our patients and providing quality care. Please note the following standards:

Behavior – For your safety and the safety of others, we will not tolerate rude or inappropriate behavior at any of our facilities. We value our staff and our patients and aim to treat everyone with equal respect. **Displaying inappropriate behavior could result in having you or your child's care dismissed from our practice immediately.** Thank you for your help and support in keeping our facilities safe and patient friendly.

Because of the critical lack of access to dental services in our area, missed appointments are taken very seriously

Although we will make every effort to remind you of your upcoming dental appointment by phone or by mail, you are ultimately responsible for remembering your appointment date and time.

Broken Appointments:

- Patients are only allowed ONE broken appointment in a 12-month time period.
- Broken appointments (BA) are any time you are scheduled for an appointment, and you do not show for that appointment.
- ***If you have more than 2 BAs in a twelve-month period, you will be marked as "Same Day Only"***

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Cancellations:

- If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know *so that we can offer your appointment to another patient*.
- Late cancellations may be considered broken appointments
- Late arrivals may also be considered broken appointments. If you do not arrive by 10 minutes after the start time of your appointment, your appointment may be given to another patient.

Appointment Confirmation:

- You must call to confirm your appointment by the business day before.
- Our practice closes at 5:00pm. It is your responsibility to call, text or email.
- If you do not call to confirm at least 24 hours before the start of your appointment, we may give your appointment away to another patient. ***This may be considered a broken appointment.***

"Same Day Only" – Same Day & Walk In:

- ***If for any reason, a patient misses their appointment or cancels late for a second time within a 12-month period***, they will not be *scheduled* another appointment.
- However, these patients are still welcome to receive their dental care from us.
- Patients who have broken two appointments with us can either call us in the morning for a "same day appointment," or they may come to our clinic as a "walk-in patient."

We always do our best to work our walk-in patients into the schedule if it does not interfere with the care of previously scheduled patients; but please understand there is no guarantee that you will receive an appointment as a "walk-in."

If you have questions, please ask to speak with the Practice Administrator at your respective location.

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Section 6: Telemedicine/Telephonic Agreement

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the tele medicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and maintain confidentiality of the information obtained. I further understand that I will be informed of their medical presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regards to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language I understand.

By signing this form, I certify:

I have read or had this form read and/or had this form explained to me

That I fully understand its contents.

That I have been given many opportunities to ask questions and that any questions have been answered to my satisfaction.

Patient/Parent Signature:_____ Date: _____

Witness/Team member: _____ Date: _____