THE CENTER
FOR ORAL SURGERY
of Las Vegas

Carlos H. Letelier, M.D., D.M.D., D.D.S.
Board Certified
Specializing in Dental Implants

Ph:(702) 367-6666
Fx: (702) 367-9555
www.lasvegasoms.com

10115 W. Twain Avenue
Suite 100
Las Vegas, Nevada 89147

Welcome to our office!

I am extending a warm welcome and am looking forward to meeting with you.

My team and I are committed to providing specialized care for your individualized needs. In fact, our mission is to provide the highest level of treatment in a friendly and inviting environment. We want you to have the very best experience possible and will do everything we can to make this happen. Thank you for choosing us!

The enclosed brochure will give you some information about us, including our location, phone number and driving directions. I also encourage you to visit our website at www.lasvegasoms.com where you will find lots of resources and pictures to help you get acquainted with who we are and what we do. Some people enjoy our facebook page at OralSurgery LasVegas@facebook.com.

I am looking forward to discussing your treatment with you and will be happy to answer any questions you have. Feel free to make a list of things to go over during our appointment.

Again, I look forward to meeting you and welcome to our oral surgery family!

Dr. Carlos Letelier, M.D., D.M.D., D.D.S.

INFORMATION ABOUT YOUR APPOINTMENT

Again, thank you for choosing our office to provide for your Oral and Maxillofacial Surgery care. Enclosed, please find patient information forms which we would like you to fill out and bring with you to your scheduled appointment. For your convenience, you may also fax these completed forms to our office at 702-367-9555. Please do **NOT** mail these forms back to us.

Please remember to bring the following items to your appointment:

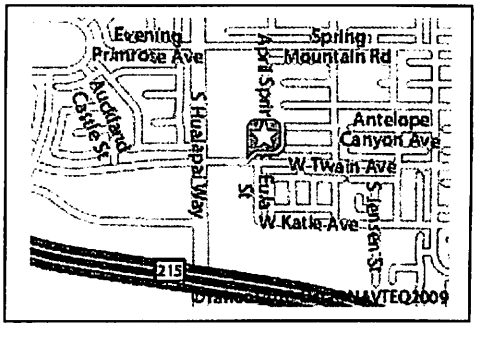
- Complete packet of forms
- Valid photo ID
- Any insurance cards – **BOTH** medical and dental
- Referral form (if applicable)
- Panoramic X-ray (less than 6 months old – if available)
- List of all medications you are currently taking and their dosages.
- List of any other concerns you may want us to address.

If you are having surgery, please also note the following Pre-Surgical Instructions:

- You should not have anything to eat or drink for at least **6** hours prior to your surgery (medications should be taken with a small sip of water)
- Have someone available to drive you home
- Do not smoke for six hours prior
- Dress in comfortable clothing: short-sleeve shirt, low heeled shoes (if possible, wear a T-shirt & tennis shoes) – no sandals please

Please note that co-payments will be requested on the date of treatment. If you have any questions regarding these forms, please give us a call. Also be assured that you will have ample time for discussion with Dr. Letelier prior to any treatment. We look forward to meeting you! Thank you,

Dr. Carlos H. Letelier and Staff



Patient Number:_____
Procedure(s):

Insurance Verification Form

Please fill out the top half only. Please print.

No Charge Pano : Y / N

Today's Date:

Patient's Name:	Address:
Patient's Date of Birth:	Apt# City and Zip:
Patient's Social Security Number:	Phone Number:
E-mail address:	Cell Phone Number:
PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Employer:	Employer:
Under Whose Name:	Under Whose Name:
Social Security Number:	Social Security Number:
Date of Birth:	Date of Birth:
FOR OFFICE USE ONLY	
Deductible Met: Y / N $	Deductible Met: Y / N $
Oral Surgery %: Prevent %:	Oral Surgery %: Prevent %:
MAX$: USED$: AVAIL$:	MAX$: USED$: AVAIL$:
PPO: Spoke to:	PPO: Spoke to:
PANO: CONS:	PANO: CONS:
Pre-Authorization Required: Y / N	Pre-Authorization Required: Y / N
Waiting Period: Y / N Claims Pending: Y / N	Waiting Period: Y / N Claims Pending: Y / N
GA: Y / N W/One tooth:	GA: Y / N W/One tooth:
Group # Effective Date:	Group # Effective Date:
Insurance Address & Phone Number: Date Verified:	Insurance Address & Phone Number: Date Verified:
0363- 6010- 4263- 4266- 9610- 7953-	0363- 6010- 4263- 4266- 9610- 7953-

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PATIENT INFORMATION

Full Name _____ Nickname _____ Age ___ Birth date _____ Sex___

Address_____City_____ State___ Zip _____Soc. Sec. # _____

Home Phone _____ Cell Phone _____ E-mail _____

☐ **DO YOU PREFER TO BE TEXT MESSAGED?** ☐ **DO YOU PREFER TO BE EMAILED?**

Employer _____Occupation _____ Work Phone_____

General Dentist_____ Orthodontist Name(if applicable)_____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PATIENT)

Name_____ Birth date_____ Phone # _____

Address_____City_____State_____ Zip _____

Soc. Sec. # _____ Employer _____Work Phone_____

INSURANCE INFORMATION

DENTAL INSURANCE: Insurance Co._____ Employer_____

Under Whose Name_____ DOB_____ SS#_____

MEDICAL INSURANCE: Insurance Co._____ Employer_____

Under Whose Name_____ DOB_____ SS#_____

ADDITIONAL INS. COVERAGE: Ins. Co._____ Employer_____

Under Whose Name_____ DOB_____ SS#_____

EMERGENCY CONTACT

Name_____ Phone # _____ Relationship _____

_____ _____ _____

Signature of Responsible Party ** Date Patient ID

****ASSIGNMENT OF BENEFITS: By signing, I hereby guarantee payment of *all* charges incurred for the account of the patient described above. I also hereby assign and direct you to pay any surgical or medical attention benefits under this claim directly to Dr. Carlos Letelier, The Center for Surgical Arts, or The Center for Oral Surgery. I also hereby authorize this office to furnish from its records any information requested by the insurance companies in connection with the assignments above. I understand that when applicable, my insurance is being billed as a courtesy and any co-pays and/or unmet deductibles are asked for prior to procedures. If we are unable to verify benefit coverage or if you are not working with insurance, balance will be asked to be paid *in full* before procedures. I have read and understand that I am assuming financial responsibility for the care rendered. Notice of Privacy Practices and Infection Control Policies are available for review upon request. MEDICARE PATIENTS PLEASE NOTE: We have elected to opt out of the Medicare Program, and thus cannot bill for services that would be Medicare eligible. We are not a provider of any medical insurance carrier and all medical procedures will require payment *in full* at time of service.**

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MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Age: Sex: M / F Height: _____ Weight: _____

Referring Doctor _____ Reason for Visit _____

For the following questions, circle Yes or No, whichever applies. Your answers will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____ / _____ / _____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. Family Physician Name and Phone Number: _____
6. **Have you *ever* had *any* serious illness, operations or hospitalizations?** ..... Yes No
   If so, describe (including dates) _____
   _____
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. **Do you have or have you had any of the following? *(If "Yes" circle each condition that applies)***
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, rheumatic heart disease, low blood pressure, or any other heart condition ..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
   c. Sinus trouble ..... Yes No
   d. Asthma or hay fever ..... Yes No
   e. Fainting spells or seizures ..... Yes No
   f. Diabetes ..... Yes No
   g. Hepatitis, jaundice or liver disease ..... Yes No
   h. Frequent or recurring mouth sores ..... Yes No
   i. Thyroid problems ..... Yes No
   j. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   k. Arthritis or painful, swollen joints or glands ..... Yes No
   l. Osteoporosis ..... Yes No
   m. Stomach ulcer or hyperacidity ..... Yes No
   n. Kidney trouble ..... Yes No
   o. Tuberculosis ..... Yes No
   p. Persistent cough or cough that produces blood ..... Yes No
   q. Clicking or popping of jaw joint, difficulty opening mouth, grind or clench teeth, TMJ ..... Yes No
      If so, describe treatment received and when _____
   r. Epilepsy or neurological disorder ..... Yes No
   s. Cancer ..... Yes No
   t. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had treatment for a tumor or growth? ..... Yes No
12. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
13. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____

CONTINUE ON BACK ⇒

14. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, describe:_____
15. Do you smoke or chew Tobacco? ..... Yes No
    If so, how much per day?_____For how many years? _____
16. Is there any past history of alcohol or chemical dependency or emotional disorder? ..... Yes No
17. Are you wearing contact lenses? ..... Yes No
18. Do you have any removable dental appliances? ..... Yes No
19. Are you taking or have you *ever* taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia,Zometa or Denosumab)? ..... Yes No
20. Are you taking *any* medications including diet pills, birth control, non-prescription, antiangiogenic drugs, supplements or vitamins;

(If "Yes," LIST IN CHART BELOW) ..... Yes No

CURRENT MEDICATIONS (including any supplements and vitamins)

Name of Medication	Dosage	When is the Medication Taken	Purpose
Example: RX abc	*5mg*	*2 times a day, morning & night*	*Ulcers*

21. **Do you have any allergies?*(If "Yes", LIST IN CHART BELOW, INCLUDING ALLERGIES TO PEANUTS, SOY OR EGGS)*** ..... Yes No

ALLERGIES

Name of MedicationOR food product.	Reaction or Intolerance Experienced (symptoms, severity)

FOR WOMEN ONLY

22. Are you pregnant or is there any chance you might be pregnant? ..... Yes No
23. Are you nursing? ..... Yes No

I have read and understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. I have the opportunity to discuss Health History with my doctor.

Date:_____ Patient's Signature:_____ Doctor's Initials _____

Office Use only- Medications Prescribed to Patient On Day of Surgery:

_____

_____

_____

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Privacy Consent

By signing this consent form, you are giving consent to Carlos H Letelier, M.D.,D.M.D.,D.D.S./Center for Oral Surgery and Center for Surgical Arts to use and disclose your protected health information for the purposes of treatment, payment and the health care operations. We have developed a Notice of Privacy Practices that provides more detailed information about how, and under what circumstances, we may use and disclose your protected health information for treatment, payment and health care operations.

Please know that you have the right to review our Notice of Privacy Practices before signing this consent form. In fact, we encourage you to read the entire Notice PRIOR to signing this form. You also have the right to request that we restrict how we may use and disclose your protected health information. We are not required by law, however, to agree to your request. But, if we do decide to grant your request, we are bound by our agreement with you. You also have the right to revoke this consent in writing, unless we have already used or disclosed your protected health information in reliance on this consent.

Dr. Carlos H. Letelier, M.D., D.M.D., D.D.S. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Dr. Carlos H. Letelier, M.D.,D.M.D.,D.D.S. may mail to my home or other designated locations any items that assist Dr. Carlos H. Letelier, M.D.,D.M.D.,D.D.S. in carrying out treatment, payment, and healthcare operations such as appointment reminder cards and patient statements.

Our Notice of Privacy Practices may be changed from time to time. In the event that we make changes to our Notice, you may obtain a copy of our revised Notice by calling (702)367-6666 or sending a written request to our office.

According to JCAHO standards, we must inquire if you have a "DO NOT RESUSCITATE" order (DNR) or living will. In the rare event that the need for resuscitation should arise, we resuscitate our patients until paramedics arrive.

In respect of our patients' privacy and healing process, we request no cell phone usage, photos and/or videotaping/recording. This is due to HIPPA confidentiality regulations. Thanks you for your cooperation and respect for our patient's and employee's privacy.

NAME (print): _____

Signature: _____ Date: _____

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Medicare Private Contract

By signing contract I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare or its agents for services provided by Dr. Carlos H. Letelier, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of service rendered by Dr. Carlos H. Letelier-Center for surgical arts, and I understand that no claims will be submitted to Medicare and no Medicare Reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.

I understand that Medigap plans do not, and other health and medical care insurance plans may elect not to, make payment for such services.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted.

I understand that Dr. Carlos H. Letelier is not excluded from participation in the Medicare Program under Section 1228 of the Social Security Act or pursuant to any other legal authority. I also understand that the rules that the rules explained above are those mandated by **MEDICARE** and not by the non-participating physicians.

This contract is effective on August 22, 2019, will expire on August 22, 2021.

Patient Name: _____Date:_____

Patient's Signature: _____Oral and Maxillofacial Surgeon's

Signature: Carlos H Letelier

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OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to provide you with a successful treatment and a pleasant experience. Our Insurance Department and Patient Finance Counselors will work very hard to make sure that you get the maximum reimbursement possible.

INSURANCE AND INSURANCE COLLECTION

Insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny and reduce payments. It is much easier to maximize your reimbursement if we work together to get your claim processed so you may be asked to call and check claim status if the claim has not been paid past thirty (30) days. After your surgery, insurance companies occasionally reimburse you, the patient, even though an assignment of benefits has been properly executed. Should this occur and your balance has not been satisfied, you are obligated to endorse and forward all payments to this office within 24 hours.

FORMS OF PAYMENT

We accept Cash, Checks, all major credit cards, debit cards and check cards. We offer *CareCredit and Springstone* as our extended payment options. Our Patient Finance Counselors can give you details on how to apply.

INSURANCE CO-PAYMENTS

We verbally obtain your benefits from your insurance and determine your estimated co-payment, however, this is an estimate only and this does not alleviate you of your financial obligations. After your claim is submitted and paid, you may still have a remaining balance and will receive a statement due upon receipt.

TYPES OF INSURANCE

Non-Contracted or Indemnity Insurance Plan:

We will bill your insurance as a courtesy, a convenience, and a service to you; however, we may require 100% of the bill to be paid at the time of service.

PPO Dental Plans:

We are providers with several dental insurance carriers. Please verify with our office staff if your insurance is one we are contracted with. If we are a contracted provider, your percentage co-pay plus any deductible is collected on the date of service. We obtain verbal estimates from your insurance company regarding your benefits for your treatment on the date of service. This amount may not reflect pending claims or non covered procedures. Additional monies may be due after insurance receives claim and processed according to your plan.

Medical Insurance:

This office is NOT a Medical Provider with any medical insurance carriers. For all medical treatments provided, you may be asked for payment in full at the time of service. Please note that your insurance may deny the claim if you have not pre-authorized your surgical procedure or elected to go out of network. We will be happy to bill them as a courtesy to you (except Medicare). Because we are accredited with JCAHO, a claim may be submitted to your medical insurance for a facility fee (The Center for Surgical Arts) and supplies. The patient will not be responsible for the amount the insurance does not pay on this claim. However, if payment is sent to you, we ask that you forward it to our office.

Medicaid:
You must have a valid, full benefit Medicaid card for the current month along with a picture ID. You are responsible for payment of procedures not covered by Medicaid. This office does not accept pending Medicaid status or the HMO plan with Ameri Group or Smart Choice HPN.

Secondary Insurers:
Having more than one insurances DOES NOT necessarily mean that your services are covered 100%. Insurances do a coordination of benefits, and secondary insurers will pay as a supplement of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balance after your insurance(s) has paid.

Dental Implants/Cosmetic Procedures:
Extended appointments are provided and components must be ordered for these types of procedures. Only rarely is insurance coverage available to cover these fees. In order to secure your surgery date/time, all fees are due and payable one week prior to your scheduled procedure(s).

Bone Grafting, Biopsies and Removal of lesions
Frequently, these procedures are not covered by insurance plans. For this reason, we require payment for these procedures at the time of service. As a courtesy, we will bill your insurance company and attempt to obtain coverage. If any payment is made by your insurance company for these procedures, we will reimburse you the corresponding amount.

CT Scans:
CT scans may not be a covered benefit with your insurance, so we do ask for the fee at the time of service. We will bill your insurance as a courtesy to you. If your insurance pays, it will then be reimbursed to you. If we are a provider with your insurance and your insurance allows CT scans, you will get the provider fee.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Divorce Decrees:
This office is NOT a party to any divorce decrees. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Unplanned Procedures:
Surgery is not an exact science. As such, procedures not initially contemplated may be necessary during your surgery or at a later date. This may include a post-operative x-ray which may be necessary following your procedure. Further charges may apply.

Minor Patients:
The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

Refunds:
In the event that your account is overpaid after we receive payment from your insurance, refunds will be made at the middle and at the end of the month and mailed in the name of the patient.

Collections:
Please be advised that this office cooperates with the Clark County District Attorney's Office to prevent bad check losses. Unless satisfactory arrangements are made with our Financial Department, delinquent accounts are sent to a collection agency. Please be aware that being referred to this type of agency may adversely affect your credit rating.

I have read and understand each section in this financial policy. By signing this form, I agree to all the procedures and policies described.

_____ _____
Signature of Responsible Party Date

_____ _____
Signature of Co-responsible Party Date