



Leix Dental
8505 Redtail Dr Suite J, Village of Lakewood, IL 60014
(815) 455-8186
leixdental@gmail.com

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NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Address Information

Mobile phone:		Street address:	
Home phone:		City:	
Email:		State:	
		ZIP:	

Emergency Contact

Work Information

Full Name:		Street address:	
Phone number:		City:	
Relation:		State:	
		ZIP:	

Patient's signature:

Date:



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PRIVACY POLICY CONSENT

NOTICE OF PRIVACY PRACTICES LEIX DENTAL

Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW MEDICAL 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 MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Telephone: 815-455-8186

8505 Redtail Dr, Suite J, Lakewood, IL 60014

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- * healthcare quality assessment and improvement activities;
- * reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- * conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- * business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please check this box.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- * for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- * to avert a serious and imminent threat to health or safety;
- * for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- * for research;
- * in response to court and administrative orders and other lawful process;
- * to law enforcement officials with regard to crime victims and criminal activities;
- * to coroners, medical examiners, funeral directors and organ procurement organizations;
- * to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- * as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- 1) HIV/AIDS;
- 2) Mental Health;
- 3) Genetic Tests (in accordance with GINA 2009);
- 4) Alcohol and drug abuse;
- 5) Sexually transmitted diseases and reproductive health information; and
- 6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

- 1) You have a right to see and get a copy of your health records.
- 2) You have a right to amend your health information.
- 3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
- 4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
- 5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by checking this box.
- 6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
- 7) You have a right to restrict who receives your information.
- 8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
- 9) If you believe your rights are being denied or your health information is not being protected, you can:
 - a. File a complaint with your provider or health insurer
 - b. File a complaint with the U.S. Government
- 10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs you may do so by checking this box.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Patient's signature:

Date:

FINANCIAL POLICY

Leix Dental Financial Policy

Effective March 1, 2026

To continue providing the highest quality dental care and to streamline our billing process, we are updating our financial policy effective **March 1, 2026**.

CARD ON FILE REQUIREMENT

All patients are required to keep a valid credit or debit card on file with our office. Card information will be securely stored and used only in accordance with this policy.

PAYMENT

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

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, unless other arrangements are made.

INSURANCE CLAIMS

Although we are a non-contracted provider with insurances, we will continue to submit claims to your insurance company as a courtesy. Please understand:

- Insurance coverage is a contract between you and your insurance company.
- We cannot guarantee payment of claims or the amount your insurance will pay.
- Any remaining balance after insurance processes the claim is the patient's responsibility.

If your insurance company does not process and pay your claim within **45 days**, the outstanding balance will be transferred to you and billed accordingly. Payment will be expected within 30 days of the statement date.

PATIENT BALANCES

You will receive a statement for any balance accrued, and payment is due within 30 days of the statement date. Any balances not paid within 30 days will be automatically charged to the card on file.

UNPAID BALANCE

Any unpaid balance over 30 days past due will result in an automatic \$35 rebilling fee applied to your account. Failure to pay your bill within 90 days may result in the account being turned over to a collection agency, unless other arrangements are made. Accounts sent to collections will be subject to a collection fee of 33% of the outstanding account balance, which will be added to the amount owed.

MISSED APPOINTMENTS

If you find you are unable to keep your reserved appointment, there will be no cancellation fee applied if you call us *at least 48 hours in advance*. Should you fail to contact us prior to 48 hours, the following will apply:

A cancellation fee of \$50 per visit for the missed/cancelled scheduled appointment up to 60 minutes.

A cancellation fee of \$75 per visit for the missed/cancelled scheduled appointment up to 90 minutes.

For appointments longer than 90 minutes, a deposit may be required. Appointments canceled with less than 48 hours notice may be subject to a cancellation fee of the full deposit amount.

If you have any questions regarding this update, please contact our office. We appreciate your understanding and thank you for trusting us with your dental care.

By receiving treatment in our office, you acknowledge and agree to this financial policy and authorize our office to charge the card on file in accordance with these terms.

Patient's signature:

Date:



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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Leix Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Leix Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Leix Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Leix Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Leix Dental.

Patient's signature:

Date:



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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Leix Dental, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Leix Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Leix Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Leix Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Leix Dental.

Patient's signature:

Date: