Patient Information

Today's Date:_____

Name:_____
Last name First name Middle Initial

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Email_____

Who may we thank for referring you?_____

In case of Emergency:_____ Relationship to Patient:_____

Home phone:_____ Work # :_____ Cell :_____

Primary Insurance

Policy holder:_____
Last Name First name Middle Initial

Relationship to patient:_____ Birth date:_____

Soc. Sec. #:_____ Home phone # :_____

Address:_____

Policy holder employer:_____

Occupation:_____ Business phone # :_____

Insurance Co.: _____Phone#:_____

Group # :_____ Subscriber ID # :_____

Secondary Insurance

Subscribers Name_____
Last name First name Middle initial

Relationship to patient: _____ Birth date:_____

Soc. Sec. #:_____Cell phone #:_____

Subscriber employed by:_____

Insurance Co:_____ Ins. Phone # :_____

Group #:_____ Subscriber #:_____

CANCELATION POLICY

We ask that you give our office 48hrs notice before canceling an appointment. You **MUST** provide at least 24hrs notice or a fee of $50.00 per hour of a missed appointment will be added to your account and another appt will not be scheduled until paid. After 3 missed appointments without proper notice we will no longer reserve time for you in our office.

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal we need your assistance and your understanding of our payment policy. Payment for services is due at the time services are rendered unless other arrangements have been approved in advance by our staff. We accept cash, check, credit card, or care credit.
We will gladly discuss your proposed treatment and answer any questions you may have. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all Services are a covered benefit in all contracts. Some plans arbitrarily select certain services they will not cover. We encourage you to talk with your insurance and familiarize yourself with your plan.

In most cases we can file your insurance for you. We will do your best to estimate for you what insurance will pay and what the patient portion will be for you treatment. **The estimated patient portion will be due at the time of treatment. Any amount not paid by your insurance, regardless of the reason, is your responsibility.** We therefore **require** a credit card to be on file for any balance not paid by your insurance company.

Financial Information

PREFFERRED METHOD OF PAYMENT:

☐ Cash/ Check on Day of treatment ☐ Care Credit

☐ Visa / Master card / American Express / Discover / Debit Card

Person responsible for this account: Relationship: Phone #

_____ _____ _____

Terms & Conditions

As a Condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

Financial Responsibility: I Further agree to pay all finance charges, collection cost, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of 90 days from the date of the patients' examination.

In consideration of the professional services rendered to me by the Doctor and/or his staff, I agree to pay for all treatment performed to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended.

Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further tremor condition. I further agree that in the event that this office shall institute any legal proceedings against me with respect to amounts owed by me for services rendered I will be responsible to pay all costs incurred including all attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signed _____ Date: _____

MICHAEL J. SMITH, D.D.S.

Patient Consent/Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Michael J. Smith, D.D.S., our staff, and our business associates (specialists) for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice. We will also post any revised Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree on these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use and disclosure of your protected health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgement of receipt of OUR NOTICE of privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand and agree to the consent of the notice of privacy.

Name_____ Date_____

If refused, please specify the exact reason why the patient chose not to sign the consent/acknowledgement of notice of privacy.