PATIENT INFORMATION

TODAY'S DATE _____

PATIENT'S NAME_____ AGE _____ DOB_____ MALE _____FEMALE _____
LAST FIRST MI

IF PATIENT IS A MINOR, GIVE NAME OF PARENT OR LEGAL GUARDIAN _____ RELATIONSHIP _____

RESIDENCE ADDRESS_____ FOR HOW LONG_____ OWN____ RENT_____
STREET CITY ZIP

PATIENT IS: __MARRIED __SINGLE __DIVORCED __SEPARATED __WIDOWED __MINOR

EMAIL _____

DRIVER'S LICENSE NO. _____ SOCIAL SECURITY NO._____

RES. PHONE _____

EMPLOYED BY _____ HOW LONG _____

CELL PHONE _____

BUSINESS ADDRESS _____
STREET CITY ZIP

BUS. PHONE _____

SPOUSE'S NAME _____ EMPLOYED BY _____ HOW LONG _____

FORMER DENTIST _____ REASON FOR LEAVING _____

PURPOSE OF APPOINTMENT _____

WHOM MAY WE THANK FOR REFERRING YOU?_____PHARMACY_____

EMERCENTY CONTACT:_____PHONE_____

PHYSICIAN NAME_____PHONE_____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____RELATIONSHIP TO PATIENT _____

ADDRESS _____
STREET CITY ZIP

RES. PHONE _____ CELL PHONE _____ BUS. PHONE _____

NAME OF INSURANCE CO. _____ INSURANCE PHONE _____GROUP # _____

SUBSCRIBER _____ DOB _____ SS#_____ RELATIONSHIP TO PATIENT _____

NAME OF SECONDARY INSURANCE CO. _____ INSURANCE PHONE _____ GROUP # _____

SUBSCRIBER_____ DOB _____ SS#_____ RELATIONSHIP TO PATIENT _____

TERMS & CONDITIONS

AS A CONDITION OF TREATMENT BY THIS OFFICE, I UNDERSTAND FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COST 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 SERVICE PERFORMED WITHOUT PRIOR FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIMES SERVICES ARE PERFORMED.

I UNDERSTAND THAT DENTAL SERVICES, FURNISHED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES. IF I CARRY INSURANCE, I UNDERSTAND THAT 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 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. 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 SIX MONTHS FRO THE DATE OF THE PATIENT'S EXAMINATION.

IN CONDERATION OF THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR AND/ OR HIS STAFF, I AGREE TO PAY, THEREFORE, THE REASONALBE VALUE OF SAID SERVICES SHALL NOT CONSTITUTE A WAIVER OF ANY FURTHER TERM OR CONDITION. I FURTHER AGREE THAT IN THE EVENT THAT EITHER THIS OFFICE OR I INSTITUTE ANY LEGAL PROCEEDINGS WITH RESPECT TO AMOUNTS OWED BY ME FOR SERVICES RENDERED, THE PREVALLING PARTY IN SUCH PROCEEDINGS SHALL BE ENTITTLED TO RECOVER ALL COST INCURRED INCLUDING REASONABLE ATTORNEY'S AND/OR COLLECTION FEES.

I GRANT MY PERMISSION TO YOU, OR YOUR ASSIGNS, TO TELEPHONE ME AT HOME OR AT MY WORK TO DISCUSS MATTERS RELATED TO THIS FORM.
I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

SIGNED _____ DATE _____

PLEASE FILL OUT BOTH SIDES OF FORM

HEALTH QUESTIONAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to our dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/ or circle Yes or No where applicable.

Medical History

- Are your in good health?.....Yes No
- Date of last physical exam……...Yes No
- Are you under the care of a physician?.....Yes No
  If so, what is the condition being treated _____
- Have you ever had any serious illness or operation?.....Yes No
  If so what was the illness or operation?_____
- Have you ever been hospitalized?.....Yes No
  If so, what for? _____
- Are you taking any __medications __ drugs or __ herbs……...Yes No
  If so, what? _____
- Are you using any recreational drugs (marijuana, cocaine, etc.)? ……..Yes No
- Have you ever been told to pre-medicated with antibiotics for all your dental treatment……..……Yes No
- Are you allergic to any drugs or materials? __penicillin, __tetracycline, __sulfa drugs, __aspirin, __ codeine, __ latex, __other …….Yes No
  If other explain _____
- Do you have or have you had any of the following: (Please circle **Y** for yes and **N** for no.- answer each question)

Y N Anemia	Y N Cerebral Palsy	Y N Headaches	Y N Mental Disorder	Y N Stomach Ulcers
Y N Arthritis	Y N Chemotherapy	Y N Hemophilia	Y N Mitral Valve Prolapse	Y N Sickle Cell Disease
Y N Angina Pectoris	Y N Cortisone Medicine	Y N Head Injuries	Y N Nervous Disorders	Y N Sleep Apnea
Y N Allergies or Hives	Y N Congenital Heart Lesions	Y N Heart Failure	Y N Osteoporosis	Y N Snoring
Y N Asthma	Y N Diabetes	Y N Heart Murmur	Y N Psychiatric Treatment	Y N Tonsillitis
Y N Artificial Prosthesis	Y N Drug Addiction	Y N Heart Ailments	Y N Pain in Jaw or Joints	Y N Thyroid disease
Y N Allergies to Metals	Y N Difficulty Swallowing	Y N Heart Attack	Y N Rheumatism	Y N Tuberculosis (TB)
Y N Aids	Y N Emphysema	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Tumors or Growths
Y N Bruise Easily	Y N Excessive Bleeding	Y N HIV Related Complex	Y N Respiratory Disease	Y N TMJ
Y N Blood Disease	Y N Epilepsy or Seizures	Y N Hepatitis or jaundice	Y N Radiation Treatment	Y N Ulcers
Y N Blood Transfusion	Y N Fainting Spells	Y N Implants	Y N Stroke	Y N Venereal Disease
Y N Cancer	Y N Glaucoma	Y N Joint Replacement	Y N Seizures	Y N Other
Y N Cold Sores	Y N Herpes	Y N Kidney Disease	Y N Scarlet Fever	_____
Y N Chicken Pox	Y N Hay Fever	Y N Liver Disease	Y N Sinus Trouble	_____

- Do you have any disease, condition or problem not listed that you think we should know about? ……..Yes No
  If so, what? _____
- Do you wear a cardiac pacemaker, or have you had heart surgery? ……Yes No
- Do you smoke? If yes how much? __Cigarettes __ Cigars Packs per day?_____ ……...Yes No
- Have you ever taken the drugs _Fen-Phen, __ Redux or any, __Diet Drug ……Yes No
- Are you pregnant? If so how many months? ……..……..……Yes No
- Do you take any birth control medication or hormones?.....Yes No

Dental History

- Have you ever had local anesthetic (Novocaine, etc.)? ……Yes No
- Have you ever had any unfavorable reaction from a local anesthetic? ……..Yes No
- Have you had any serious trouble associated with any previous dental treatment?.....Yes No
  If yes, explain. _____
- How long since your last full mouth x-rays? _____ last dental cleaning _____
- Does dental treatment make you nervous _____
- Would you desire to be pre-sedated _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Date _____Patients Signature (or responsible party if under 18) _____

Office Use
Reviewed by _____ Lic #_____ Date:_____

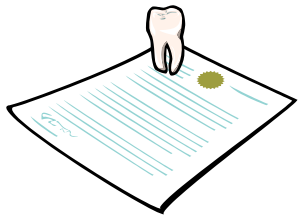
Dental Centers of the Carolinas

1241 W. Clemmonsville Road
Winston-Salem, NC 27103

5710 W. Gate City Blvd., Suite H
Greensboro, NC 27407

Dr. Kelly 336 766-7966

Notice of Privacy Practices



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. YOU MAY REQUEST A COPY OF THIS NOTICE AT ANY TIME.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to: (1) maintain the privacy of medical information provided to us; (2) provide not of our legal duties and privacy practices, and (3) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our employees and staff as well as other health professional, physicians and insurance companies, or any other entity that would be in contact with our other offices located in Greensboro and Winston Salem, North Carolina. In addition, these individuals, entities, sites and locations may share medical information with each other for treatment, payment or hospital operation described in this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

1. Your name, address and phone number and social security number.
2. Information relating to your medical history,
3. Your insurance information and coverage.
4. Information concerning your doctor, nurse or other medical professionals.

In addition, we will gather certain medical information such as intra-oral photos, x-rays, etc. and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care"-such as the referring physicians, your other doctors, your health plan, family members and close friends.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes via phone, fax, postal mail and email. All of the types of uses and disclosures on information are described below, but not every use or discloser in a category is listed.

REQUIRED DISCLOSURES

We are required to disclose health information about you to the Secretary Health and Human Service, upon request, to determine our compliance with (HIPPA) and to you in accordance with your right to access and the right to receive an accounting of disclosures, as described below.

FOR TREATMENT

We may include health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to access the health of your teeth.

FOR PAYMENT

We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give payer information about your current medical condition so that it will pay for your examinations or other services that we have furnished to you. We may also need to inform your payer of the treatment you are going to receive or to obtain prior approval or to determine whether services are covered.

FOR HEALTH CARE OPERATIONS

We may use and disclose information about you for the general operations of our business. For example, we sometimes arrange for auditors or other consultants to review our practice and evaluate our operations, and review with us any way to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

PUBLIC POLICY USE AND DISCLOSURES

There are a number of public policy reasons why we may disclose information about you which is described below:

1: We may disclose health information about you when we are required to do so by federal, state, or local law.

2: We may disclose health information (PHI) about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health department authority, which has authority to collect or receive personal health information (PHI) for purposes of preventing or controlling disease, injury or disability, or a direction of a public health authority, to an official of a foreign government that is acting collaboration with a public health authority. Public health authorities include state health departments, the center for Disease Control and the Food and Drug Administration, the Occupational Health Administration and the Environmental Protection Agency, to name a few.

3: We are also permitted to disclose protected health information (PHI) to a public health authority and other government agency authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information (PHI) to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or geological product deviations, to tract products, to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person that may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether and individual has a work-related illness or injury.

4: We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorized the disclosure or it is required or authorized by law.

5: We may disclose health information about you in the connection with certain health oversight activities of licensing and other health oversight agencies, which are authorized by law. Health oversight activities include audit investigation inspections, licensure or disciplinary action, and civil criminal or administrative proceeding or action or any other activity necessary of:

- The health care systems

- Governmental benefit programs for which information is relevant to determining beneficial eligibility,
- Entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or
- Entities subject to civil rights laws for which information is necessary for determining compliance.

6: We may disclose your health information as required by law, including in response to a warrant, subpoena, or any other order of a court or administrative hearing body or to assist law enforcement to identify or locate a suspect, fugitive, material witness or missing person. Disclosures or law enforcement purposes also permit us to make disclosures about victims of crimes and death of an individual, among others.

7: We may release a patient's health information to:
- A coroner or medical examiner to identify a deceased person or determine the cause of death,
- Funeral directors
- An organ procurement organization, transplant center, and eye or tissue bank if you are an organ donor.

8: We may release your health information to worker's compensation or similar programs which provide benefits for work related injuries or illness with out regard to fault.

9: Health information about you also may be disclosed when necessary to prevent a serious threat to your health and safety or the health safety of others

10: If you are a member of the Armed Forces, we may release health information about you for your activities deemed necessary by military command authorities. We also may release health about foreign military personnel to their appropriate foreign authority.

11: We may disclose your protected health information (PHI) for legal administrative proceedings that may involve you. We may release such information upon order of a court or and administrative tribunal.

12: We may also release protected health information (PHI) in the absence of such an order in response or a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

13: If you are an inmate, we may release protected health information (PHI) about you to a correctional institution where you are incarcerated or law enforcement officials in certain situations such as where the information is necessary for your treatment, health, safety of others.

OUR BUSINESS ASSOCIATES

We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

DISCLOSERS TO PERSONS ASSISTING IN YOUR CARE OR PAYMENT FOR YOUR CARE

We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that you are a part of your "circle of care"-such as your spouse, your parents, your siblings and other doctors involved with your care or an aide who may be providing services to you. We may also use and disclose health information about a patient to disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition, or death. Generally, we will obtain information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

APPOINTMENT REMINDERS

We may use and disclose medical information to contact you as a reminder that you have an appointment or to remind you to schedule an appointment. A message may be left on voice mail or answering machine at the phone number you have provided.

TREATMENT ALTERNATIVES

We may use and disclose your personal information in order to inform you about or recommend to you possible treatment options, alternatives, or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF A PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission you may revoke the permission in writing at any time. If you revoke your permission, we will no longer disclose personal information about you for the reasons covered by your written authorization except to the extent we have already relied in your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the way we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit your disclosures to persons assisting in your care or payment for your care. We will consider your request, but we are not required to accept it. If you pay for your procedure(s) in full, you have the right to restrict that information from being provided to you insurance company.

You have the right to request that you receive communications containing your protected health information from us by alternative means other locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us or authorizations to make and uses and disclosures before April 14, 2003, among others. If you ask for this information from us more than once every (12) months, we may charge you a fee.

You have the right to a copy of this notice in paper form. You may ask for a copy anytime. When making a request for an amendment to your records, you must date your request and state the reason for making this request. If you have any complaints concerning our privacy practices please contact us or you may e-file your complaint with HIPPA complaint 7500 security Blvd., C5-24-04, Baltimore, MD, 21244

.....

I have received the Notice of Privacy Practices for Dental Centers of the Carolinas and hereby agree to the release and use of this information as described above.

_____

Signature **Date**

_____

Witness **Date**

REV 12/2016

REQUEST FOR ALTERNATIVE COMMUNICATIONS
Andrew W. Kelly, DDS
Dental Centers of the Carolinas

Participant Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As allowed by the Privacy Regulations, I wish this office to provide the following "Alternative" means of communicating my Protected Health Information:

o Mailing Address
If appropriate, please contact me at the following address:

_____

o Phone
If appropriate, please contact me by telephone at the following number(s):

_____

o Fax
If appropriate, please contact me by fax at the following number(s):

_____

o E-Mail
If appropriate, please contact me by E-mail at the following E-mail address(s):

_____

o Text Message
If appropriate, please contact me by test message at the following cell phone number(s):

_____

o I have the following additional requests for confidential communications regarding my Protected Health Information: (Please explain) I understand that there may be additional costs associated with the request and I agree to reimburse this office for such costs.

_____

_____

Signature _____ Date _____

o Accepted as requested o Modified as noted: _

_____ _____

Authorized Signature of Practice Date

Form 4.501

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Patient Name: _____

Address: _____ City: _____ State:__Zip: _____

As required by HIPPA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I hereby authorize Dental Health Center of the Carolinas and its employees to disclose my Protected Health Information to the following person, health care provider, or business associate.

_____

Patient Health Information authorized to be disclosed, Check all that apply:

____Patient Information ____Claim Information

____Payment Information ____Benefits Information

____Explanation of Benefits ____All Information Requested

For the specific use or purpose of (describe in detail):

_____

_____

Effective dates for this authorization ____/____/____ through ____/____/____. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient heath information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

Smile Evaluation Checklist

Name: _____Date:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too long or too short?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Do your gums show too much when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing crowns or dental work that you consider "ugly"?	YES	NO
Are you self-conscious of your teeth and/or smile?	YES	NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a "new smile"?	YES	NO

What concerns do you have regarding dental treatment to improve your smile?

Fear of treatment
Time of treatment concerns
Financial concerns
Distance to office
Not understanding treatment
Embarrassment
Other

AGREEMENT AS TO RESOULUTION OF CONCERNS

"I, Patient/Guardian" shall be understood to mean _____, (insert name of patient or guardian) "Doctor(s)" shall be understood to mean Andrew W Kelly D.D.S. of Dental Centers of the Carolinas.

Further, I understand that I am entering into a contractual relationship with the Doctor for professional care. Further I understand that meritless and frivolous claims for medical/dental malpractice have adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Doctor, I the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Doctor.

Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, I (the patient or my representative) agree to use dental witness(es) who are board-certified in the same specialty as the Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and or code of conduct defined for expert witnesses by the American Dental Association.

In further consideration for this, Dr Andrew W. Kelly agrees to the same stipulations.

_____ _____

Doctor Patient or Guardian

_____ _____

Effective from Date of Treatment Date of Signature

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior to service, the Office Policies and Procedures in the following areas of concern.

Please INITIAL each of the items below

____This office employs licensed, board certified Dentist and Hygienist, who will be involved in your patient care and providing your dental treatment.

____Policy on cancellation and rescheduling requires 48 business hours notice in advance. (Please respond by calling us back to let us know you received the reminder call). Thank you.

____Failure to give 48 business hours advance notice of cancellation may result in a minimum of $50.00 for the Office Visit.

____ Patients are responsible to know their insurance benefits prior to their first visit. Any amount not paid by your insurance benefits is still your responsibility.

____NSF checks has a ($50.00) recovery fee and (Thereafter cash only).

____Statements are billed twice a month. Expectant payment is within 10 days of the statement date.

____Insurance Billing- We bill your insurance the same day of service, electronically.

____Notification of change of insurance, job, name, address and phone number is the patient's responsibility.

____All established patient phone calls are triaged through the dental assistants and/or office staff.

____Diagnostic and Treatment Codes for Billing will NOT be altered for insurance billing purposes.

____Pharmacies: Patients must supply the office with their pharmacy name and phone number.

____Co-pay and Service Fees are due at the time of service and prior to treatment for patient comfort.

____If pre-treatment instructions have not been followed, your procedure may be canceled.

____18 years and under must be accompanied by a parent or guardian.

____ I have been informed the of **$50.00** processing fee for dental records and/or X-rays.

____ I have been informed of the $359.00 fee for copies of each CT scan (3D images).

My initials above and my signature below signify that I have read the above items and understand the counseling I have received.

Printed Name_____**Signature**_____**Date**_____

FINANCIAL OPTIONS & GUIDELINES

This form is designed to notify you of our office policies regarding methods of payments we offer you, including acceptance of insurance.

METHOD OF PAYMENT

____*CASH, CHECK , CREDIT CARD/ DISCOVERY CARD*
____ *VISA, MASTERCARD ,AMERICAN EXP, DEBIT CARD*
____ *THIRD PARTY FINANCING (CC) & (C-1) PLEASE ASK!*

OPERATIONAL POLICIES

Major Procedures require a deposit to hold the space and time that is completely dedicated for your treatment, therefore we must secure that space and time with a deposit that assures us you will be keeping that appointment.

INSURANCE RELATIONSHIP

We are very happy you have an insurance to assist you in the payment for these procedures, however, please know that our relationship is with you, our patient, not the insurance company. We bill and trace your insurance for payment, however you are ultimately responsible for payments.

PAYMENT AT THE TIME OF SERVICE

Payments are made at the time of services. Our patients appreciate taking care of their business with the front desk, prior to treatment and while waiting. This cuts down on the time they have to spend waiting at the end of service. Also while their comfort level is higher.

Print Name _____ Signature_____ Date_____