PATIENT ACQUAINTANCE FORM

Date: ___/___/___

Patient: _____ M / F Date of Birth: ____/____/____
Address: _____ SSN: ____-____-_____
_____ Home# (___)____-_____
_____ Work# (___)____-_____
Email: _____ Cell# (___)____-_____

Person Responsible for Account (if other than self): _____
Address: _____ Relationship: _____
_____
_____

Primary Insurance:
Insured: _____ Date of Birth: ____/____/_____
Employer: _____ SSN: ____-____-_____
Insurance Co: _____ Ins. ID#: _____
Mail to: _____ Group#: _____
_____

Secondary Insurance:
Insured: _____ Date of Birth: ____/____/_____
Employer: _____ SSN: ____-____-_____
Insurance Co: _____ Ins. ID#: _____
Mail to: _____ Group#: _____
_____

Who can we thank for referring you to our office? _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing below, I give my consent to use or disclose my protected health information to carry out treatment, payment activities and healthcare operations.

Your consent permits us to do the following: (Keep in mind that none of these are new practices.)

- Communicate between staff members for your optimal care
- Contact/consult with a referral doctor on your behalf
- Phone in a prescription to your pharmacy
- Call your home, cell or work number
- Mail or email reminder cards, bills and correspondence to your home or alternate address
- Have prosthetic prescriptions completed by our labs
- Submit claims to insurance
- Other healthcare-related and payment-related functions

You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matter about your protected health information. You may have a copy of this Notice upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we do so, we will issue a revised notice containing the changes.

You have the right to restrict or revoke this consent upon written notification, however the office is not obligated to agree to the restriction, and the restriction/revocation will not be effective prior to the date of receipt of notice.

I give my permission for the office to also speak with/contact the following person(s) about my health: _____
_____
_____

Signed: _____ Date: _____

South Riding Cosmetic & Family Dentistry
FINANCIAL INFORMATION

We are committed to providing you with the best possible dental care. In order to begin a long lasting, professional relationship, we ask for your understanding of and cooperation with our financial policy.

We will submit claims to ANY PPO insurance plan, however we are NOT in-network with all PPOs. - Refer to your plan website to confirm our participation PRIOR to your appointment. ESTIMATED copayments will be due at time of service. We will process payments per your plan Explanation of Benefits. **Any remaining balance after insurance payment has been received will be due upon receipt of statement for all patients**.

Since Plans differ from patient to patient and employer to employer, it is impossible for our staff to know specifics of your plan. We expect that you have reviewed your benefits PRIOR to attending your appointment. **We do not make phone calls to your insurance company at the time of your appointment to inquire about your coverage, with the exception of your initial visit.** Treatment will be advised at a level of care that we would expect for ourselves. This recommendation may be outside of your employer-selected coverage. It is our responsibility to offer the best care, not only what insurance may offer.

OTHER IMPORTANT ITEMS:

1) We will be happy to submit a pre-treatment estimate to your insurance company at your request and after you have provided appropriate insurance information. Pre-treatment estimates are NOT a guarantee of payment.
2) Interest, at the rate of 1.5% per month, will be applied to all balances exceeding 90 days.
3) Accounts exceeding 60 days since last payment will be reviewed for collection by a third party. **If you receive a statement you do not understand, please call us immediately.**
4) If an account requires collection by a third party, the patient/guarantor will be responsible for all collections fees, attorney's fees, court fees, and any/all other costs incurred to collect your debt.
5) **A minimum $50.00 fee will be charged to your account for broken appointments and appointments canceled without 24 business hours prior notice. Evenings, Nights, Weekends and holidays are not considered business hours.**
6) Prosthetic cases (crown, bridge, veneers, etc.) and whitening trays will not be delivered until final payment has been received.
7) Military only: I authorize you to talk to my/my spouse's superiors if I am delinquent in paying my account.
8) There will be a charge of $25.00 for all returned checks. Checks which are not rectified immediately will be surrendered to a third-party collector for legal action.
9) **A deposit will be required to reserve time on our schedule in some instances,** such as crowns, periodontal procedures and lengthy restorative appointments. This deposit will apply to your estimated copay unless the appointment is broken or cancelled within 24 business hours. It will then be applied as a broken appointment fee and will be non-refundable.

I have read and understand the above information

_____

Patient, Parent or Guardian