Patient Information

Patient Name: _____ Preferred Name: _____

Address: _____

SS#:_____-____-_____ Date of Birth: _____/____/_____Drivers License Number: _____

Mobile: _____ Home: _____ Work: _____

Occupation: _____ Employer: _____

Employer Address: _____

Please Circle: Male / Female Married / Single / Divorced / Separated / Widowed

In Case of Emergency Please Notify: _____

Relationship to Patient: _____ Contact Number: _____

Financial Responsible Party ____Initial if same as above

Name: _____Relationship to Patient: _____

Address (if different from patient): _____

SS#: _____-____-_____ Date of Birth: _____/____/_____Drivers License Number: _____

Mobile: _____ Home: _____ Work: _____

Occupation: _____ Employer: _____

Employer Address: _____

Please Circle: Male / Female Married / Single / Divorced / Separated / Widowed

Insurance Information

Insurance Carrier: _____ Phone Number: _____

PO Box: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Employer: _____Subscriber ID: _____ Group Number: _____

Who may we thank for referring you? _____

Release of Information

Patient Name: _____Date: _____

Taylor'd Smiles is authorized to release protected heath information about this patient to the entities named below. The purpose is to inform others about the patient's information while following the patient's instructions.

Person/Entity to receive information:

Check each person/entity that you approve to receive information and the type of information to be released.

____ Spouse/Significant Other/Partner ____ Medical ____ Financial ____Labs, Xrays, Other

_____ (name & phone)

____ Parent ____ Medical ____ Financial ____Labs, Xrays, Other

_____ (name & phone)

____ Other ____ Medical ____ Financial ____Labs, Xrays, Other

_____ (name & phone)

May we leave information in a personal voice mail____, text message____, and/or email____?

I understand that I have the right to revoke or amend this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed and described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will only be effective going forward.

I understand the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned to signing. This authorization shall be in effect until revoked by myself.

Patient Signature: _____ Date: _____

Office Policies

Patient Name: _____

Patient Responsibility

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities

Payment is due at the time services are rendered. Financial arrangements are discussed at the time treatment is planned and, if needed, a financial agreement is completed in advance of performing any treatment with our practice. We accept Cash, Check, Visa, MC, Discover, American Express, and Care Credit as forms of payment. As a courtesy for our self pay patients, we offer a discount for paying treatment costs in full with cash or check.

For overdue balances a **monthly finance charge of 1.5% (18% annually**) will be added to any balance, including unpaid insurance in excess of 60 days. If a third party (collection agency/legal action) should become involved in the collection of fees owed to Taylor'd Smiles, all cost associated with those collection proceedings will be charged to the responsible party.

For new patients coming into the office for **an emergency, all treatment is required to be paid in full** at the time of service. We will file your services to your insurance company and they will reimburse you directly.

Insurance

As a courtesy to you, we will file your services to your insurance company and follow up with them for sixty (60) days. If no payment has been received from your insurance company within that time period you will be responsible for any remaining balance.

Your dental plan is a contract between you and your employer and the dental insurance company. Benefits and payments are based on the terms of the contract negotiated between you /your employer and the insurance company. Please note that you are responsible for knowing and understanding your benefits. You should contact your HR department directly if you have any questions regarding your benefits or if you feel your insurance company has not paid your claim appropriately. **It is your responsibility to insure you have provided our office with current and correct insurance information.**

Our office is currently in network with Delta Dental Premier, BCBS of NC, and United Health Care.

We make a diligent effort to verify your annual maximum, deductible, and plan information. If treatment is needed, our Treatment Coordinator will go over an **ESTIMATE** of your out of pocket costs based on the information provided to us by your insurance company. Our estimates are dependent on complete and accurate information provided by your insurance company. You are ultimately responsible for the entire treatment cost regardless of what your insurance pays for.

Recare Appointments

We individualize your dental care so your recare appointments will be specific to your dental needs, not to your insurance plan timetable. Depending on your oral condition you may be placed on a three, four, or six month recare schedule. If you have periodontal disease or previous periodontal therapy you will remain on periodontal maintenance (a treatment, not a preventative therapy) until such time as the doctor and hygienist determines moving you to preventative therapy will not place you at risk of future infection and destruction of oral tissues.

Scheduling

We structure our daily schedule to allow us to provide the optimum care you deserve from your dental provider. In order to achieve this, we depend on your accountability for **your** scheduled appointments. If for any reason you must cancel or change your appointment, we respectfully require **48 business hours notice**. We understand that there are rare circumstances beyond your control that would prohibit you from providing this notice and we will gladly take that into consideration.

We reserve the right to charge your account **a Cancellation Fee of $50** to cover the cost of room set up and supplies prepared especially for your appointment. Please note that for habitual late cancellations/reschedules or failed appointments any further appointments will be at the discretion of the Office Manager.

In an attempt to meet the scheduling needs of all of our patients and ensure that our patients are committed to their scheduled appointments, any appointment scheduled for two hours or more requires a **$100 deposit** upon scheduling. This deposit will go toward your treatment cost except in cases where appropriate notice is not given for a cancelation or reschedule. Should this occur the deposit will be forfeited.

Your appointment length is personalized to your individual care; therefore we need the entire appointment time to provide you with optimal care. If you arrive more than **15 minutes late** for your appointment, you may be asked to reschedule based upon the flexibility of our schedule. If this happens, it will be considered a missed appointment. Individual circumstances for late arrival will be considered in the assessment of a $50 fee to your account.

Communication

We know lives and schedules are hectic and that is why we have invested in a Courtesy Reminder System to assist our patients with their calendars. You may elect to receive a text message, an email, a postcard, or a phone call. If you would like, you may receive all reminder types of communication. Please honor our investment by acknowledging receipt of the communications and responding as requested. Most reminders will provide enough advance notice to allow proper cancelation/reschedule consideration should that be necessary.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in

email form may be misdirected, disclosed to, or intercepted by unauthorized third parties. However, you may consent to receive emails from us regarding your treatment. You may opt out of emails at any time.

Please choose one of the following:

____ I consent and accept the risk in receiving reminders, health and other sensitive or confidential information via text and email. Email address: _____

____ I consent only to receiving appointment reminders via text.

Authorizations

- I affirm that the information I provided today is correct to the best of my knowledge. I authorize Taylor'd Smiles to perform any necessary dental services that I may need and have consented to during diagnosis and treatment phases.
- I have read all of the above policies regarding financials, scheduling, and communication and have had all of my questions regarding these policies answered by a staff member of Taylor'd Smiles.
- I understand for overdue balances a **monthly finance charge of 1.5% (18% annually**) will be added to my balance, including unpaid insurance in excess of 60 days. If a third party (collection agency/legal action) should become involved in the collection of fees owed to Taylor'd Smiles, all cost associated with those collection proceedings will be charged to the responsible parties account.

Patient Name: _____Date of Birth: _____

Patient Signature: _____Date: _____

Please initial one of the following:

____ I authorize the release of information necessary to process my dental benefit claims. I authorize payment, otherwise payable to me, directly to Taylor'd Smiles or its doctors.

____ I do not authorize assignment of payment to Taylor'd Smiles. I will pay for my services in full and will be responsible for submission of my own dental insurance claims.

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Health Information

Patient Name: _____Date of Birth: ___/___/____

I have had full opportunity to read and consider the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: _____

Relationship to the Patient: _____

For Office Use Only

We were unable to obtain a written acknowledgement of the receipt of Notice of Privacy Practices because:

____Individual refused to sign.

____Unable to communicate with the patient for the following reason:

_____

____An emergency situation existed and a signature was not possible at the time.

____Other: _____

Prepared By: _____ Position: _____

Signature: _____Date: _____