Spouse or Responsible Party (Insurance Member/Subscriber Information)

The following information is: ☐ Same as Patient ☐ the person responsible for payment ☐ the patient's spouse

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insurance member: _____ Is insured a patient? ☐ Yes ☐
Last First MI

Member's Birth Date: _____ ID #: _____ Group #: _____

Member's Social Security Number: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company Name and Address: _____ _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

CANCELLATION POLICY

A 24-hour notice is required to cancel or change an appointment. A $35 fee <u>WILL</u> be charged to you if a Cleaning/Checkup appointment is changed or cancelled without 24 hours' notice. A $70 fee <u>WILL</u> be charged if a treatment appointment is changed or cancelled without 24 hours' notice. You may also be charged a $35 late fee for being more than 10 minutes late to any appointment. By signing below, you are agreeing to our Cancellation Policy. We appreciate your cooperation!

Patient's signature: _____

Date: _____

Cell number to text appointment reminders to: _____

Email for appointment reminders: _____

3145 GREEN VALLEY ROAD
SUITE 101
VESTAVIA HILLS, ALABAMA 35243
(205) 970-7292

FINANCIAL POLICY

We are pleased that you have chosen us for your dental care. We want to establish a long and pleasant relationship with you and your family. We understand that the filing of dental insurance can be a very complicated and time-consuming task. We want to assist you in any way possible to receive the maximum benefit from your insurance. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.

1. We are contracted as a *preferred* provider for the following insurance companies:

- Blue Cross/Blue Shield of Alabama
- Delta Dental
- United Concordia
- Cigna
- Humana
- MetLife
- Southland
- Assurant/SunLife
- Aetna
- United Healthcare
- Tricare – Active Duty
- Guardian
- DentaNet
- Dental Guard Network

All applicable deductibles, co-payments, and co-insurance amounts are due at the time services are rendered. We accept cash, check, Master Card, Visa, Discover, and American Express. Some dental services may not be fully covered by your contract. In the event a given procedure is not fully covered, payment for these services is your responsibility at the time of service. In the event the balance is unpaid and turned over for collections, any and all debts such as reasonable collection fees, attorney fees and court costs will be added to the account and is your responsibility.

- While the filing of insurance claims is a courtesy that we gladly extend to you, **ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

If your insurance is not listed above, please see the following paragraph.

1. If your insurance is through a company with whom we are not contracted:
   - Please check your contract carefully to determine if you are required to see a preferred provider for that company.

Understand that if you choose to see a non-preferred provider, your insurance may not pay the full amount or pay at all. You are responsible for the difference.

   - Your insurance is a contract between you and your insurance company. Our office is not a party to that contract.

3. If you do not have dental insurance, all payments are due at time of service.

In order to facilitate accurate and prompt reimbursement, we request that you give us complete and correct information. If you have any questions regarding your insurance coverage or our financial policy, please do not hesitate to ask.

By my signature, I acknowledge that I have read the above financial policy and I understand and agree to comply with said policy.

Signature of Responsibility Party_____ **Date** _____

3145 GREEN VALLEY ROAD
SUITE 101
VESTAVIA HILLS, ALABAMA 35243
(205) 970-7292

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ◊ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ◊ Obtaining payment from third party payers (e.g. my insurance company);
- ◊ The day-to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

ADA Guide for Compliance with "The New Red Flags Rule for Protection of Identify Theft and Detection Response Program" are in place.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Signature:_____

Date:_____