Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

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

Cell: _____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

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

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____Driver's License_____

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 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: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon 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 previous financial arrangements, must be paid in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, 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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Financial Policy

Payment Options

_____Cash

_____Check

_____Major Credit Cards – Visa, Mastercard, American Express, and Discover

_____Patient Payment Plans through; Care Credit- No interest or
Extended payment plans, which our office can give you more information regarding these.

Patient's without Dental Insurance

Our office policy requires that payment is due in full on the date of service.

Patient's with Dental Insurance

We would like to highlight a *MISCONCEPTION*- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment. All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are *governed* by *Premiums paid*. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care! The treatment recommended by our office is never based on what your insurance company will pay. Your health and treatment should not be governed by an insurance contract. We will file your insurance as a courtesy to you, but we do expect your estimated payment and necessary deductible to be paid at the time of service. The estimated co-payment is merely an estimate and not a guarantee of payment by your insurance company. It should also be understood, that the dental insurance contract is between the patient and the insurance company. The patient bears the ultimate financial responsibility.

We hope you find this information helpful. Please take the time to view your contract thoroughly so we may better serve you. As always, feel free to ask any questions for clarification on services, billing and insurance

**There will be a $25.00 charge on all returned checks.
**There will also be a $50.00 charge per hour on appointments that are not cancelled 48 hours prior to appointment.

Significant costs are incurred in carrying our patient's accounts. To control these costs and help keep fees down, it is necessary to adhere to this financial policy.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to my dental care. I hereby authorize payment of my dental benefits to Broad Park Family Dentistry.

_____ _____
Signature Date

_____
Printed Name

PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FORM FOR PATIENT

Broad Park Family Dentistry
1750 East Broad
Mansfield, Texas 76063

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but it is not mandatory for me to sign in order to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bonded to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I authorize Broad Park Family Dentistry to leave messages at the phone numbers I have provided, which may include answering machines and/or voice mails regarding upcoming appointments.

DOB_____
PATIENT NAME_____
SIGNATURE_____
RELATIONSHIP TO PATIENT_____
DATE_____