ToothMasters

Financial Responsibility Agreement/Insurance Assignment/HIPAA Agreement

Due to the increase cost for billing, patient's failure to fulfill their financial obligations, and other changes in healthcare regulation, it is necessary for our office to implement the policies below. If you have any questions or concerns regarding these policies, you may contact our practice administrator.

CO-PAYMENTS: Co-payments are required when services are rendered.

BALANCES: All balances must be paid in full before seeing the physician.

NO SHOWS: Our office charges $30 for appointments not kept

FMLA/RECORDS: Our office will be charging a $5.00 fee for filling out FMLA forms and for copying records or x-rays. This charge is not reimbursed by your insurance. Payment can either be made at the time forms are dropped off or picked up.

CELL PHONE CALLS/TEXT MESSAGES: Eff: 02/20/2013 I, the undersigned, give ToothMasters, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers **(PHONE CALL OR TEXT MESSAGE),** for the purpose of treatment, insurance or payment.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, attorney fees and/or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other State.

WE ACCEPT VISA, MASTERCARD, DISCOVER, CARE CREDIT OR CASH.

NO CHECKS

I fully understand my financial responsibility for services rendered at ToothMasters and understand that failure to comply with these policies will result in having to reschedule any appointments until I can fulfill my responsibility.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Price all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under 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; 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 completed 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 health care 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. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Mobile: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Employer Name/Phone: _____

◯ Responsible Party is also a Dental Insurance Policy Holder for Patient

Patient Information

Address: _____

City: _____ State / Zip: _____ _____ Mobile: _____

Home Phone: _____ Work Phone: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employer Name: _____

Employer Phone: _____

General Dentist: _____

Pref. Pharmacy/Phone: _____

Spouse Name/Phone: _____

Spouse Employer/Phone: _____

Section 3

I was referred by: _____

My Emergency Contact is: _____

Emerg. Phone#: _____

May we reach you by text? ◯ Yes ◯ No

Student Status: ◯ Full Time ◯ Part Time

My Employment Status:
◯ Full Time ◯ Part Time ◯ Retired

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured ID number _____ Insured Birth Date: _____ Group Number _____

Employer: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Ins. Company: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In consideration of the services rendered or to be rendered, the undersigned agree(s) to pay for all services rendered in a manner acceptable with the office. In the event of default on payment, the undersigned agrees to pay all costs of collection, including attorney fees. The undersigned hereby waives all rights and claims of exemptions under state and federal laws.

_____ _____

Signature of Patient or Legal Guardian Date