Carolina Dental Alliance

FINANCIAL POLICY

Please remember to keep our office informed of any changes in your insurance coverage or employment. If you have moved or changed your phone number, please make sure to update this information during your appointment. We remind you that the responsibility rests with the patient being treated or the parent/guardian to ensure full payment for treatment.

- **If You Do Not Have Insurance,** we ask that you pay for your office visit at the time of your appointment.
- **If You Have Private Insurance,** please give your insurance card and any necessary insurance forms to front desk staff during your appointment. As a convenience to you, we can complete the claim forms and submit them directly to your insurance company. You may be required to make a payment (co-payment, partial payment, deductible, etc) for your visit today by cash or credit card. Most insurance coverage involves deductibles and/or percentage allowances with the result that the entire bill is seldom covered in full by the insurance company. If your insurance company does not cover the full cost of treatment as charged, you will be sent a statement for the remaining balance. We recommend you become directly involved in communication with your insurance company in order to expedite payment. We know questions can arise on insurance matters and these can be discussed with our front desk staff. We will be happy to help you receive maximum benefits; however, the agreement of the insurance company to pay for dental care is a contract between you and the insurance company and we have no leverage to obtain payment from your insurance carrier.
- **Assignment of Benefits and Release of Information:** I authorize payment directly to the dental office and the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- **Fees** Dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) or contracted rates, and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment. You will be responsible for any balance excluded.

CROWNS, BRIDGES, DENTURES, PARTIALS, AND OCCLUSAL GUARDS REQUIRE WORK FROM AN OUTSIDE LAB FOR COMPLETION OF TREATMENT. THESE TREATMENTS WILL REQUIRE A PREPAYMENT OF 50% OF THE TOTAL COST OF TREATMENT TO COVER OUR LAB FEES AND CHAIR TIME. **IF YOU DO NOT RETURN FOR THE DELIVERY OF THIS TREATMENT THIS AMOUNT WILL NOT BE REFUNDED**. This is to cover the cost of the lab bill, supplies, and labor we incurred.

Delinquency: Your account is considered delinquent if there have been no payments in 90 days. If your account falls into delinquency, you agree to pay any and all collection agency charges, attorney fees and court fees. Accounts turned over to collections will incur a 25% collections fee added to the balance.

I have received and read the Financial Terms and understand that I am responsible for any unpaid balances on the account. By signing this document, I hereby agree to be the responsible party for payment over this account.

____/____/____ _____

Date Name (printed) Relationship to Patient, if applicable

_____

Name (signature)

Carolina Dental Alliance

Patient Registration

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Mailing Address:

_____

City_____ State _____ Zip_____

Home Phone: _____ Cell Phone: _____

Responsible Party (ONLY COMPLETE IF SOMEONE OTHER THAN PATIENT)

First Name: _____ Last Name_____

Date of Birth: _____ SSN: _____

Mailing Address:_____

Home Phone: _____ Cell Phone: _____

Insurance Information:

Name of Insured: _____

Relationship to Insured: _____

Insured SSN: _____ Insured Date of Birth: _____

Employer:

_____

Please let our Patient Coordinator know if you have secondary coverage

EMAIL ADDRESS: _____

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

Carolina Dental Alliance

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____
have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

_____

Carolina Dental Alliance

Important Information
For Our Patients

Dental Insurance

We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please bring your insurance explanation of benefits booklet and your insurance card to your first visit. Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

Payment Options

- We accept All major credit cards, Care Credit, money order, cash, or personal check.
- A convenient interest free payment plan through an outside financial institution.

Appointments

In order to allow the best possible care for our patients, we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a 24-hour notice is expected. Please note...a fee of $35 will be charged to the patient for cancellations or broken appointments less than 24 hours in advance. We do require our patients to confirm their dental appointments in advance. You may confirm by email, text or calling the office. If the appointment is not confirmed, we may schedule another patient in your time slot. Thank you in advance for your understanding.

Signature:_____

Patient Agreement

- I understand that my insurance policy is an agreement between the insurance company and me, therefore I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Carolina Dental Alliance.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

Signature: _____ **Date:** _____

Carolina Dental Alliance

Consent for Treatment

I give this practice, _____ , my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature:_____ Date: _____
(Patient, parent, or legal guardian)

If signed by patient representative, state relationship to patient
_____

Carolina Dental Alliance

Name: _____

Email Address: _____

REFERRED TO THE DENTIST BY:

Newspaper	Facebook
Billboard	Radio
Yellow Pages	TV
Direct Mail	Walk by / Drive by
Google/Bing/Yahoo Search	Brochure
Doctor	Insurance Company
Dentist	Urgent Care

If referred by friend or family, who do we thank for referring you?

_____

Other_____

Were you contacted by your hygienist the day before your appointment? Yes / No

HIPAA Communication Permissions

By law, without your authorization, we are unable to communicate with your spouse, adult children, caregivers, or parents if you are over 18.

We will need your permission to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial information

Please indicate below the names of people and their relationship to you, who we may communicate with and what information we are allowed to communicate:

Person 1: _____

☐Appointments ☐Dental/Health/Treatment ☐Account/Financial

Person 2: _____

☐Appointments ☐Dental/Health/Treatment ☐Account/Financial

☐ **I do not wish to allow my information to be shared with anyone including my spouse or other family member and/or guardian.**

Please select your preferred methods of communication:

☐ You may contact me at my home telephone number: _____

☐ You may contact me at my mobile telephone number: _____

☐ You may text my mobile telephone number.

☐ You may contact me at my work telephone number: _____

☐ You may send me an *unencrypted* email at: _____

Printed Name: _____ **Date:** _____

Patient/Legal Guardian Signature: _____

Carolina Dental Alliance

Medical Information Release Form

Patient Name: _____ Patient DOB:_____

Release of Information

[ ] I authorize the release of my information including the diagnosis, records (chart notes, x-rays, intra oral pictures), examinations rendered to me, and billing and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child: _____

[ ] Parent/Guardian: _____

[ ] Other: _____

[ ] My information is **NOT** to be released to anyone other than myself.

Electronic Mail

[ ] My personal medical information may be released to me via electronic mail (email).

Email address: _____

This *Release of Information* remains in effect until terminated by me in writing.

Patient/Guardian Signature: _____ Date:_____

Witness Signature:_____ Date:_____