Park Forest Dental
ANOTHER REASON TO SMILE

OFFICE AGREEMENT

General:

I understand that regardless of any insurance status, I am responsible for the balance due on my account. I am responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

Payments:

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Insurance:

We will be submitting an insurance claim for services rendered in our office on your behalf as convenience for you. It is your responsibility to inform us of any changes in your insurance carrier or policy. Our treatment is based on the dental need of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company. As a courtesy we can contact your insurance company for a pre-determination of payment for major services. However, the pre-determination amount provided by the insurance company is not a guarantee of payment. We will help in any way possible to file your claim or handle any insurance queries you may have. If you do not receive any correspondence from your insurance company within 60 days of your dental visit, please contact our office to inform us of the situation.

Missed Appointments:

When appointments are scheduled, that time is set-aside specifically for you and your needs so that we may provide you with the best care. When a patient fails to come to scheduled appointment or cancels without advanced notice we are unable to provide care to another patient who is in need. With this in mind **we require a notice- 48 hours or more when cancelling or rescheduling an appointment.** After **TWO broken appointments** this practice will **charge $50** to be able to accept you back as a patient in our office. After **THREE broken appointments we will no longer be able to schedule you back** as a patient in our office. We do provide a confirmation call as a COURTESY REMINDER; however, you are responsible for informing us of any changes to your phone number, address, or any other contact information.

We are here to help. If you have any questions, please feel free to ask any of us.

I authorize the release of any information and/ or x-rays relating to my dental treatment to the insurance company, attorney, or collection agency in collecting the cost of the services provided. I authorize payment from my insurance company directly to my Dentist. My signature on file applies to myself and all dependents listed on my insurance plan.

I authorize the release of any information and/ or x-rays to dental offices where I have been referred or to another office of my choosing. Payment: We accept Cash, Check, MasterCard, Visa, Discover, American Express, and CareCredit Cards.

Name of Patient/ Legal Guardian:

Signature of Patient/ Legal Guardian:

Date:

Park Forest Dental
ANOTHER REASON TO SMILE

FINANCIAL POLICY

This form explains to all of our patients the billing process only of the office -- much like a payment agreement for a credit card, or billing policies and procedures for utility companies.

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made.

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visit's total bill. Please bring cash, check or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement.

Outstanding balances OVER 60 days will be charged to your credit card OR method of payment on file. We will send you a courtesy letter and also call you to inform you that we will be charging your credit card OR method of payment that we have on file.

Delinquent balances over 90 days old will be referred to COLLECTIONS COMPANY. All referred accounts are marked "Inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance plus a "Reactivation Fee" of 50% of the delinquent balance referred to the collection agency will be charged to your account. Only after this total account balance has been paid in full can appointments be made and your account and patient status be reactivated.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or by VISA, MasterCard, or Discover.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 48 hours advance notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $55.00 for repeatedly missed a ppointments without proper notification.

OFFICE POLICY FOR PATIENTS WITH DENTAL INSURANCE

You need to bring your insurance card and a FORM OF ID for your first vist and at any time your insurance changes.

You need to be aware that:

•We will always do our best to help you to maximize your benefits.

•Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract (we are not a participating provider).

•Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.

•Not all services are a covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

•Our staff is trained to help you with questions you may have relating to how your claim was filed , or regarding any additional information your carrier may need to process your claim. Please, ask if you have any questions.

•As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your coinsurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly. **Monthly accruing interest at the rate of 1.5% in addition to a billing fee of $5.00 per monthly statement can be avoided if your personal financial responsibility is clear within 30 days of your treatment, thereby eliminating the need for statements to be generated and mailed to you**.

•**Your claim will be filed Immediately, and benefits are expected are to be paid within 30 days**. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason. Any amounts expected to be paid by your insurance company, but not cleared by them within 45 days become your responsibility and, if not paid in a timely fashion, will begin to accumulate interest at the rate of 1.5% per month with the billing fee of $5.00 per monthly statement*. Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail.*

ACKNOWLEDGEMENT

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.

I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees. [For those patients with dental insurance who would prefer that their ins. co send payment to this office.] I hereby authorize my insurance benefits to be paid direc tly to PARK FOREST DENTAL.

I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services.

I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full.

I hereby authorize PARK FOREST DENTAL to charge my credit card or any other form of payment such as CARECREDIT, debit card etc.,after 60 days have passed since receiving treatment a the office.

I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

SIGNATURES

PATIENT SIGNTURE _____

DATE _____

STAFF INITIALS _____

Credit Card Pre-Authorization for Dental Treatment Form

Please complete & return with SIGNATURE

Via Email: support@parkforestdental.com or Via Fax: 814.238.4535

I authorize PARK FOREST DENTAL to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover as indicated below:

Check One: Visa Mastercard American Express Discover Care Credit

☐ **Balance of Charges not estimated to be paid by insurance**

Indicate one:

☐**This visit only.**

☐**All visits this year.**

☐ **Recurring charges (on-going treatment) of $_____**

Every _____ From _____ To _____.

(Frequency) (Date) (Date)

For CARE CREDIT ONLY: Please indicate how long you would like to do the no interest:

☐ **6 months** ☐ **12 months**

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

_____

Patient Name

_____

CardHolder Name

_____

CardHolder Billing Address

_____

City **State** **Zip**

_____**Mo.**_____ **Yr.** _____

Account Number **Expiration Date** **Security Code (3 digits on BACK of Visa, MC, Disc/ 4 digits on FRONT of Amex, no code needed for Care Credit)**

_____

CardHolder Signature **Date**

Park Forest Dental
ANOTHER REASON TO SMILE

HIPAA CONSENT FORM

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your PHI and of other important matters about your PHI. A copy of our Notice accompanies with this Consent will be provided upon request. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions to our Notice, at any time by contacting our office at

Phone: (814)238-4717

Fax: (814)238-4535

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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

Please ask for a physical copy in case you decide to revoke your consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Name of Patient/ Legal Guardian:

Signature of Patient/ Legal Guardian:

Date:

Park Forest Dental
ANOTHER REASON TO SMILE

Health History

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information- Patient

Full Name - Patient:

Date of Birth

Gender : M / F

Email address:

Contact Information:

Home #

Work #

Mobile #

Patient mailing address

Patient billing address

Emergency contact

Emergency #

Family doctor name:

Family doctor #

Do you have any of the following diseases or problems:

- ☐ Active Tuberculosis?
- ☐ Persistent cough greater than a 3 week duration?
- ☐ Cough that produces blood?
- ☐ Been exposed to anyone with tuberculosis?

If you answer YES to any of the 4 items above, please stop and return this form to the receptionist.

Insurance Information

Social Security number

Occupation

Subscriber's Employer (Who do you work for?)

PLEASE BRING YOUR DENTAL INSURANCE CARD TO THE OFFICE WITH YOU FOR VERIFICATION.

Name of the Insurance Plan?

Insurance ID number:

Insurance Subscriber's Social Security Number:

Insurance Subscriber's Date of Birth:

Has your insurance information changed since your last visit?

Dental Information ("Tick/ Check" where applicable)

- ☐ Do your gums bleed when you brush or floss?
- ☐ Are you currently experiencing dental pain or discomfort?
- ☐ Are your teeth sensitive to cold, hot, sweets, or pressure?
- ☐ Do you have earaches or neck pains?
- ☐ Does food or floss catch between your teeth?
- ☐ Do you have any clicking, popping or discomfort in your jaw?
- ☐ Have you had any periodontal (gum) treatment?
- ☐ Do you grind your teeth?
- ☐ Have you ever had orthodontic (braces) treatment?
- ☐ Do you have any sores or ulcers in your mouth?
- ☐ Have you had any problems associated with previous dental treatment?
- ☐ Do you wear partial dentures?
- ☐ Is your home water supply fluoridated?
- ☐ Do you wear full dentures?

☐ Do you drink bottled or filtered water? If yes, how many bottles?

☐ Have you ever had a serious injury to your head, neck or mouth?

Date of your last dental exam? What was done at that time?

Date/Year of last dental X-rays?

Name, address and Phone number of previous dentist , if any.

Medical Information ("Tick/ Check" where applicable)

Allergies

☐ Acetaminophen/ Tylenol®

☐ Acrylic

☐ Amoxicillin

☐ Animals

☐ Antibiotics

☐ Aspirin

☐ Barbiturates, sedatives or sleeping pills

☐ Cephelex

☐ Clindamycin

☐ Codeine

☐ Other narcotics

☐ Demerol

☐ Erythromycin

☐ Fluoride

☐ Food

☐ Hay fever/ seasonal

☐ Ibuprofen/ Motrin®/ Advil®

☐ Iodine

☐ Keflex

☐ Latex

☐ Lexapro

☐ Local anesthetic

☐ Mercury

☐ Metals

☐ Morphine

☐ NSAIDS

☐ Other

☐ Penicillin

☐ Sulfa

☐ Tetracycline

☐ Thimerasol

☐ Other

Conditions:

- ☐ Abnormal/ excessive bleeding
- ☐ Acid reflux
- ☐ AIDS or HIV infection
- ☐ Alzheimer's/ dementia
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back problems
- ☐ Blood disease
- ☐ Blood Thinners
- ☐ Blood transfusion
- ☐ Breathing problems/ respiratory disease
- ☐ Bronchitis
- ☐ Cancer/ chemotherapy/ radiation treatment
- ☐ Cardiovascular disease
- ☐ Chest pain upon exertion
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Damaged heart valves
- ☐ Diabetes
- ☐ Dizzyness
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Fear of Needles
- ☐ Frequent headaches
- ☐ Gastrointestinal disease
- ☐ G.E. Reflux/Heartburn
- ☐ Glaucoma
- ☐ Gout
- ☐ Hard to Freeze
- ☐ Hearing difficulties
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart rhythm disorder
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Jaundice or liver disease
- ☐ High blood pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Kidney problems
- ☐ Low blood pressure
- ☐ Low pain tolerance
- ☐ Lymphoma
- ☐ Malnutrition
- ☐ Medications
- ☐ Mitral valve prolapse
- ☐ Multiple Sclerosis
- ☐ Neurological disorders
- ☐ Night sweats
- ☐ Open Heart Surgery
- ☐ Osteoporosis/ Paget's disease
- ☐ Other congenital heart defects
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Persistent swollen glands in neck
- ☐ Physical Challenges
- ☐ Pregnant
- ☐ Premed
- ☐ Pre Medication
- ☐ Psychiatric care
- ☐ Recurrent Infections
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatism
- ☐ Rheumatoid arthritis
- ☐ Severe headaches/ migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted infection (STI)
- ☐ Sinus trouble
- ☐ Stents
- ☐ Stomach Troubles or Ulcers
- ☐ Stroke
- ☐ Systemic Lupus Erythematosus
- ☐ Thyroid problems
- ☐ TMJ Pain
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ Wheelchair Access
- ☐ Other

Details

Preferred pharmacy

Pharmacy #

Date of last physical exam?

☐ Have you ever reacted adversely to any medications or injections?

☐ Do you drink alcoholic beverages? How much/day?

☐ Has there been any change to your general health within the past year?

☐ Have you had a serious illness, operation or been hospitalized in the past 5 years?

☐ Are you taking any prescription or over-the-counter medicines? (Please, get a written list).

☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

☐ Do you use tobacco(smoking, snuff,chew,bidis)?

☐ Are you wearing a nicotine patch?

☐ Do you have sleep apnea?

☐ Are you pregnant?

☐ Are you nursing?

☐ Are you taking birth control or hormone replacement?

☐ Please list any surgical procedures you have undergone and when they occurred.

☐ Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

☐ Physician's phone number

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Date: _____

Signature of the Patient/Legal Guardian: _____