Patient Information

Name_____

Address_____

City_____State_____ZipCode_____

Marital Status_____Birthday_____Social Security #_____

Home #_____Work #_____Cell #_____

Person Responsible for Account_____DOB_____Relationship_____

Name of Employer_____

Address of Employer_____

Name of Primary Person on Insurance_____

Primary's Social Secruity #_____

Address_____

City_____State_____ZipCode_____

Primary's Employer_____

Insurance Company_____Policy #_____Insured DOB_____

Is the patient covered by another dental plan? (circle one) YES NO

If YES, please fill out the following:

Name of Insured_____Relationship_____DOB_____

Name of Employer_____Work #_____

Policy #_____

Who may we thank for referring you?_____

I understand that full payment is required for all services rendered in the date of services unless other arrangements are made in advance and that my insurance will be filed for me as a courtesy service. I hereby authorize the dental office to release all information necessary to secure the payment of benefits directly to me, unless other arrangements have been made. I understand that I am responsible for all charges whether or not they are covered by insurance benefits.

Signature_____ Date_____

Your appointment time is reserved for you. Please provide at least **24 hours notice should you need to change your reserved appointment time or a broken appointment fee of **$75** will be charged.***

Coastal Family Dentistry

Acknowledgement of Receipt

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use

We were unable to obtain a written achnowledge of receipt of the Notice of Privacy Practices because:

An emergency existed & a signature was not possible at the time.

The individual refused to sign.

A copy was mailed with a request for a signature by return mail.

Unable to communicate with the patient for the following reason:

Other: _____

Prepared By:

_____

Signature:

Thank you for choosing us as your dental care provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment. All patients must complete our information form and provide insurance facts before seeing the doctor.

APPLICABLE PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD and /or CARE CREDIT

Regarding Insurance

We may accept assignment from your insurance benefits. However, it is **your responsibility.**

If your insurance company has not paid in full within 45 days, you are responsible for full payment of your account and have 10 days to remit payment to this office.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

All co-pays and deductibles are due at the time of treatment.

Usual and Customary Rates

Our practice is committed to providing the best dental treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your up front charges may include a 10% allowance for your insurance company's arbitrary adjustment of the fee schedule.

Adult Patients

Adult patients are responsible for payment at the time of service.

Minor Patients

The adult accompanying a minor and the patients (or guardians of the minor) is responsible for applicable payment.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **$75.00** per office visit. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date:_____

X_____ Date:_____