

Dental Insurance

- Dental insurance benefits do not work in the same way as medical insurance. There is almost always a co-payment due from the patient for almost every procedure.
- There are “deductible” in almost all plans. At one time these deductibles were never taken out of preventive treatment (“exams, x-rays”). Recently many carriers have begun to take deductibles out of preventive treatment.
- Irrespective of any dental insurance benefits that might exist, the patient is always legally responsible for the entire cost of dental treatment.
- The extent of dental coverage is solely dependent on the dental insurance plan purchased by the employer. The higher the premium the employer pays, the greater the dental insurance benefits.
- Even if there is a written predetermination of benefits returned from the insurance carrier, it is possible that after treatment is provided, there are no insurance benefits payable.
- We (the dental office) have absolutely no power or leverage to deal with the insurance carrier. Only the employee or the contract purchasers has that power. Any complaints about benefits, payment, or coverage should be directed to Human Resources or the company owner.
- The letters “UCR” on insurance vouchers stand for Usual, Customary, and Reasonable. The dollar amount you see as UCR has no basis in reality. It is an arbitrary amount determined solely by the plan selected and insurance premium paid by the employee. There is no relationship to the actual dental office fee. The better the plan (i.e., the more premium paid), the higher the UCR will be.
- A single insurance carrier may have a dozen different UCR fees for the same procedure, same office, and same dentist.
- There is no universal coverage and payment schedule established. Just because an insurance code describing a dental service exists, it does not guarantee that it will be a paid benefit under your policy. There are many dental procedures that are necessary, and many of them are preventive, but are not covered benefits.
- Your dental benefits almost always have a yearly maximum contribution level. This amount is the most your insurance carrier is contractually obligated to pay during a defined year (calendar or otherwise). When this amount is reached, there will be no further dental benefits payable until the next benefit year. If you have already begun some additional dental treatment prior to the maximum being reached, the insurance carrier has no payment obligation beyond that of the annual maximum.
- Insurance benefits cannot be saved and carried over into the next year.

Insurance & Financial Policy

Our goal in discussing financial arrangements relative to your dental needs includes:

- to inform you of treatment alternatives
 - their respective advantages and disadvantages
 - the consequences and/or risks of limited delayed treatment and/or non-treatment
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- > Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
 - > Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows. However, this should not have control over what is in your best interest as far as treatment is concerned.
 - > For your convenience, we will estimate the your portion of the fee that you insurance company will not cover. This is just an estimate. After your insurance benefits have been paid, you are responsible for any unpaid balance. We will ask you to bring with you at the time of treatment the estimated uncovered portion of the total fee.
 - > It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. We can predetermine your benefits with your insurance company; however, this delays treatment 4-6 weeks or longer, waiting for the insurance company to respond, which may not be in the best interest of your oral health.
 - > A finance charge of 1-1 1/2% will be added to your bill if payment has not been received within 60 days. This will allow adequate time for your to ensure that your insurance benefits have been paid to your satisfaction.
 - > Should collections become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and courts costs.
 - > Our policy, and most dental plans, require a percentage fee, (co-payment) to be paid at the time of your treatment. Full payment is required at the time of service if you are not covered by a dental plan.

Payment Options:

- Cash
- Check
- Visa, Mastercard, Discover & American Express
- CareCredit

I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay an uncovered balance. I hereby authorize release of information for insurance purposes.

Signature of Patient (or Guardian)

Date

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

In Case of Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

☐ Additional Insurance

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____

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Medical History

Although our Dental Team primarily treats areas in and around your mouth the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible, Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation?

Have you ever had a serious head or neck injury?

Do you take, or have you taken, Phen-Fen or Redux?

Are you on a special diet?

Do you use tobacco?

Do you use controlled substances?

Please list any medications, pills, or drugs you are taking: _____

Women:

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Other Serious Illness |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A,B, or C | <input type="checkbox"/> Rheumatic Fever | Please Explain: _____ |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles | _____ |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease | _____ |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble | _____ |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach Disease | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Intestinal Disease | _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs | _____ |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Problems | <input type="checkbox"/> Tonsillitis | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tumors or Growths | _____ |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers | _____ |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Yellow Jaundice | _____ |

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health I will not hold my Dentist or any members of his/her Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____

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HIPPA Act

How the Health Insurance Portability and Accountability Act (HIPAA) Will Affect Your Next Dental Visit

The US Department of Health and Human Services has recently issued national health information privacy standards. The Health Insurance Portability and Accountability Act, a federally mandated law known as HIPAA, is designed to:

- provide protection for the privacy of certain identifiable health data (called protected health information [PHI]),
- ensure health insurance coverage when changing employers, and
- provide standards for facilitating electronic transfers of health care-related information.

While the privacy of your personal PHI will remain confidential, certain aspects of this law will permit disclosures of PHI to facilitate public health activities. The following charts review the types of health data disclosure allowed under HIPAA.

PHI can be disclosed with your authorization in the following categories.

You may request a limitation or restriction on the disclosure of this information. You have the right to:

- request a restriction or limit of any of the above disclosures used for treatment, payment, or office operations.
- inspect and copy information that may be used to make decisions about your care.
- request an amendment of this information if you feel it is incorrect or incomplete.
- an accounting of disclosures we have made that were not related to treatment, payment, or operations of this office.

These requests must be submitted in writing to the office manager and you will be informed of the specifics that are required.

Treatment - PHI will be used to provide appropriate treatment either by this office or other healthcare providers, diagnostic or fabrication laboratories.

Payment - PHI will be used to facilitate payment for treatment rendered. Your health plan requires this information in order to bill, collect payments, or obtain approval prior to treatment.

Healthcare Operations - In order to ensure all patients receive timely and quality care, PHI will be used to facilitate the daily operations of our practice. These include, but are not limited to:

- clinical/research studies to improve our practice
- appointment reminders by phone calls or mailings
- sign-in sheets used to notify us of your arrival
- posted appointment schedules
- information regarding your treatment options or related benefits and services
- communications with family or friends that are involved in your care or payment for your care

PHI can be disclosed without your authorization in the following categories.

As Required by Law	Judicial & Administrative Proceedings	Oversight PHI can be disclosed to a health oversight agency as authorized by law for audits, investigations, inspections, and licensure.
Public Health	Lawsuits & Disputes	Workers' Compensation PHI may be released to workers' compensation or similar programs that provide benefits for work-related injuries or illness.
Public Health Risks	Law Enforcement	Military & Veterans
Health Research PHI disclosures are permitted when required by federal, state, tribal, or local laws.	Coroners & Medical Examiners Release of PHI to officials will occur: in response to a court order, subpoena, discovery request or summons; to identify a suspected fugitive, witness, or missing person; about a victim of crime if unable to obtain permission from the person; to identify a deceased person, determine cause of death, about a death that is believed to be the result of criminal conduct; criminal conduct occurring at the practice; in emergency situations.	National Security and Intelligence Activities
Abuse, Neglect, or Domestic Violence PHI can be disclosed to prevent a threat to your health and safety or the health and safety of others.	Cadaver Organ, Eye, or Tissue Donations PHI disclosure can be made to organ banks as necessary to facilitate organ or tissue donation and transplantation.	Protective Services for the President & Others PHI may be released as authorized by law when requested by military command authorities, federal officials for national security, and protection of the president and other heads of state.