For your convenience, our patient forms have ACTIVE FIELDS you can fill out on your computer to then print. Click on the fields to enter your information.

PATIENT REGISTRATION

ID: _____ Chart ID: _____

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: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

Dental Solutions Of Columbus

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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 above? ◯ Yes ◯ No _____

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 _____ DATE _____

DENTAL SOLUTIONS

COLUMBUS CENTER
For Implants & Oral Surgery

COLUMBUS OFFICE & ORAL SURGERY CENTER:
3780 Jonathan Moore Pike, Ste. 180
Columbus, IN 47201
812-342-ZOOM (9666)
www.ColumbusDentalSolutions.com
www.ColumbusOralSurgeryCenter.com

DENTAL HEALTH QUESTIONNAIRE

1. When was your last dental visit? _____
2. Approximately how often were your appointments with your last dentist? _____
3. Are you experiencing any dental problems? If so, are they (circle one): Mild Moderate Severe
4. How often do you brush your teeth? _____ Floss? _____ Water Jet Floss? _____
5. Do you have any loose teeth? Yes No Chipped teeth? Yes No Broken teeth? Yes No
6. Are there any spaces between your teeth where food often gets stuck? Yes No
7. Do you frequently get headaches or migraines? Yes No
8. Do you have any jaw joint issues (such as popping) or pain? Yes No
9. Do you clench and/or grind your teeth when you are awake or asleep? Yes No
10. Do your teeth feel worn down? Yes No
11. Do you snore at night or commonly have a hard time sleeping well? Yes No
12. Do you have any sort of sleep apnea that you are aware of? Yes No
13. Have you ever had periodontal (gum) treatment of any kind? Yes No
14. Do your gums bleed when you brush your teeth? Yes No When you floss? Yes No
15. Have you ever had orthodontic treatment such as braces or aligner therapy? Yes No
16. Are you interested in short-term braces? Yes No
17. Do you have wisdom teeth? Yes No If so, are they bothering you? Yes No
18. Are you interested in dental implants to replace missing teeth? Yes No
19. What level of dental treatment are you interested in (circle one): Emergency Long-term
20. How do you feel about your smile? What (if any) improvements would you like to see?

21. What are your goals with our office?

Notice of Privacy Practices

Dental Solutions of Columbus
The Columbus Center for Implants and Oral Surgery
3780 Jonathan Moore Pike #180
Columbus, IN 47201
812-342-ZOOM (9666)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect __9__/__23__/__13__, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment

We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment

We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief

We may use or disclose your health information to assist in disaster relief efforts.

Required by Law

We may use or disclose your health information when we are required to do so by law.

Public Health Activities

We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS

We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation.

We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement

We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities

We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings

If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research

We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors

We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising

We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights Access

You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting

With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction

You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply**. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication

You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach

You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice

You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that

We may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

OCR NOTICE OF NONDISCRIMINATION

Source: HHS Office for Civil Rights

Dental Solutions of Columbus
complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Dental Solutions of Columbus
does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Dental Solutions of Columbus
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
○ Qualified sign language interpreters
○ Written information in other formats (large print, audio, accessible electronic formats)
• Provides free language services to people whose primary language is not English, such as:
○ Qualified interpreters
○ Information written in other languages

If you need these services, contact Maggie Boyer
If you believe that Dental Solutions of Columbus
has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Maggie Boyer Office Manager
3780 Jonathon Moore Pike Ste 180 Columbus IN 47201
812-342-9666
812-342-4434
dental.solutionsofcolumbus@gmail.com
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [*Name and Title of Civil Rights Coordinator*] is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services,
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
Toll Free: 1-800-868-1019,
800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

STANDARD CONSENT FOR DENTAL PROCEDURES

I, (print name) _____ hereby authorize Dental Solutions of Columbus and The Columbus Center for Implants and Oral Surgery, and whomever he may designate as his assistants, to perform upon me the surgery/procedure(s) that have been explained to me. I have requested and I now authorize Dental Solutions of Columbus and The Center for Implants and Oral Surgery to do whatever he deems advisable if any unforeseen condition arises in the course of this designated surgery/procedure(s) after having been advised of the risks, advantages and disadvantages, and the consequences of non-treatment. I consent to the surgery/procedure(s) after having been advised if any alternate plans of treatment available, known material risks, and the advantages and/or disadvantages of any alternative treatment.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drug that may be deemed necessary for dental treatment, and I understand that there is an element of risk inherent in the administration of any drug or anesthesia. This risk included adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs. I have been informed, and I fully understand, that inherent in any type of surgery/procedure(s) there are certain unavoidable complications. The most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of other dental restorations. Less common complications can include infection, loss or numbness in mouth and lip tissues, jaw fractures, sinus exposure and fragment remaining in the jaw which might require extensive surgery for removal. I realize that in spite of the possible complications and risks, my contemplated surgery/procedure(s) is necessary and desired by me.

I am aware that the practice of dentistry is not an exact science and that unknown conditions found may change the treatment recommendations and the fee that has been discussed and agreed by me. I understand that I will be informed of any changes to my surgery/procedure(s) at the realized convenience; however, I consent to the necessary surgery/procedure(s) deemed necessary by Dr. Dipesh Sitaram, Dr. John Weida, Dr. Jared Shelton and Dr. Gabe Hostalet to conservatively treat the condition found. I acknowledge that no guarantees have been made to me concerning the results of the surgery/procedure(s) being performed. I also consent to photographs being taken. I understand they will be used for illustration and for documentation of my treatment.

I have provided an accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any/all instructions during, and after my surgery/procedure(s) as it is explained to me and I agree to report any unanticipated reactions to Dr. Dipesh Sitaram, Dr. John Weida, Dr. Jared Shelton or Dr. Gabe Hostalet as soon as possible. I have had the opportunity to ask questions about my surgery/procedure(s) and responsive explanations have been given to me prior to signing this form. I understand that additional appointments may be required and I agree to the terms of the cancellation policy***. I understand that I will be charged a $45 fee if I fail to inform the office at least 48 hours in advance of any reserved appointment that I may cancel.***

I am knowledgeable, and I agree, to the fees associated with the treatment recommendations and I agree to be responsible for the full payment of the surgery/procedure(s) rendered. I understand that a 1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims. I understand that in addition to accrued interest charges to my outstanding balance, I will be required to pay a $40 fee each month for the billing/statement that is generated for the collections of my account. I understand that I am responsible for any fees/costs that may be incurred for the collections of my account (e.g. collection agency fees, courts and attorney fees).

_____

Patient Signature Date

_____

If minor, signature or parent or guardian

Financial Menu

Thank you for choosing Dental Solutions of Columbus and The Columbus Center for Implants & Oral Surgery, (hereinafter referred to as "we" or "Practice") for your dental care. Our goal is to provide for you a pleasant and relaxing environment with the finest care possible. We will strive to educate you about your diagnosis and treatment alternatives as well as your financial options. This document is designed to help you understand our office procedures and financial policies.

Payment

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, debit cards, checks, and cash are accepted. We will provide a written Treatment Proposal that will detail your diagnosis, treatment alternatives, estimated insurance coverage (if applicable), and your estimated portion due to begin treatment. No procedure performed on the human body can be guaranteed, as such payment is due and fees non-refundable regardless of treatment outcome. Payment for services rendered is also required if you decide to abandon a course of treatment in favor of an alternative form of treatment.

Dental Insurance

As a courtesy to you we accept, and will file, most primary insurance plans that do not require a specific provider. Please provide us with your identification card. Dental insurance is not intended to be a "pay all" service but is intended to help reduce your "out of pocket" expenses. Please be prepared to pay your deductible and estimated co-payment in full as treatment is initiated. We do NOT accept assignment of benefits for secondary insurance. Therefore any balance remaining after your primary insurance has responded is due in full. As a courtesy of those with secondary insurance's, we will prepare a claim form and submit it on your behalf when you have paid your account in full.

Insurance Payment

As a courtesy to you, we will file your primary insurance claim and are willing to wait up to 45 days from the date of service for payment. If payment has not been made, we will contact your carrier and strive to resolve any reason for delay. If unable to immediately resolve the situation a statement will be sent to you for immediate payment by the responsible party. Thereafter we will gladly assist you in attempting to obtain direct reimbursement from your carrier. WE MUST EMPHASIZE that our relationship is with you and not your carrier. Our primary concern is for your well-being and we structure our care accordingly. Insurance companies determine benefit packages and payment rates ("usual and customary" or UCR) by the plan type that is purchased by the employer/insured party-not by the level of care provided by our office. All charges including interest, accrued from the date services are rendered, are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof.

Appointments

We value your busy schedule and strive to see patients at their appointed time; we ask you to extend the same courtesy. Whenever possible please provide a minimum of 48 hours advance notice when requesting a scheduling change so that we can arrange care for other patients experiencing urgent dental needs. Failure to give adequate notice will result in a $45 office fee charged to your account that must be paid prior to rescheduling.

Returned Check Fee

A fee of $35 will be charged for any returned check. The entire outstanding balance and returned check fee must be paid immediately upon notification from our practice.

Acknowledgement, Release, and Authority

I as the patient, or as the authorized guardian or responsible party for the patient named, consent to treatment as necessary or desirable, including but not limited to drugs, medicines, performance of clinical treatment, labs, imaging, or other studies that may be performed, ordered or used by Practice. I certify that I am here only for the medical and/or dental treatment requested and also certify that I am not representing any third party or other entity.

I authorize Practice to use or release any protected health information, as used in Health Insurance Portability and Accountability Act (HIPAA) and in the manner described in Notice of Privacy Practices, to third party payers or other health practitioners as reasonably necessary for my treatment proper or for reimbursement thereof, and further hold harmless Practice from any and all damages resulting from the reasonable use thereof. I also give my consent to be contacted regarding my dental health, treatment, and scheduling and account information by telephone, e-mail, postcard, newsletter, and /or letter.

I authorize and request my insurance company to pay the Practice any monies due me as reimbursement for services rendered by Practice. I understand my insurance carrier may pay less than the total fee for services rendered and unconditionally agree to be responsible for and to pay all charges incurred on my behalf or on behalf of those for which I am responsible. I permit a copy of this authorization to be used in place of the original.

I agree to pay treble damages if I cash any insurance or other check that represent reimbursement to Practice for services rendered and I fail to immediately tender the monies due to Practice. **I agree and understand** in the event I do not pay Practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the Small Claims Court or Superior Court of Bartholomew County, Indiana and agree that Indiana law governs all matters arising out of this agreement.

I further understand a 1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims. I agree to pay

Practice a minimum fee of $45 for any appointment I schedule and fail to arrive for or cancel with less than 48 hours notice. I certify that any information I have provided today is correct to the best of my knowledge. I also understand that it is my responsibility to inform Practice or any Responsible Party and, if the patient is a minor, I certify I am legal guardian.

Patient Name: _____ Responsible Party: _____

Signed: _____

Date_____