***Christina Boesch, DMD***

***We value our patients and are committed to providing the highest quality of services. Thank you for choosing our office for your dental care.***

***PATIENT INFORMATION***

Name (Last, First, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_Sex\_\_\_ Marital Status\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Age\_\_\_\_ Soc. Sec. # \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ If child, guardian’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PRIMARY DENTAL INSURANCE***

Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have additional dental coverage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES***Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2018. You are welcome to request a copy from the front desk.

We are permitted to review and alter our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

 Authorization of PHI Disclosure The information described above may be disclosed to the following recipients:

 Name of Person #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Person #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this authorization by completing a new Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that MDSC may have already made in reliance on this authorization.

By signing below, I am acknowledging that I have received a copy of MDSC’s Notice of Privacy Practices. I am also giving MDSC consent to disclose my protected health information to the person(s) listed above until such time a new Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form is completed by me. I also understand and agree to the terms of this authorization.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***BROKEN APPOINTMENT POLICY***

We are a small private practice in a looming corporate world. We pride ourselves on providing individualized attention and personal care to our patients. In an effort to value your time, we try to run on time and not double book patients. In order to maintain this environment and not succumb to corporate practices, we have to be sure that those that are scheduled, show up to the appointments as scheduled. We need a ***minimum of 2 business day notice of any change in your appointment*** to be able to get ahold of patient that wants that time slot and to schedule them.

In an effort to avoid no-shows, reschedules, or cancellations without 2 business days’ notice our office is requiring a credit card on file for all appointments. If the appointment is kept there will be no charges to your card. However, if the appointment is missed, rescheduled, or cancelled under 2 business day notice, a ***broken appointment fee of $50*** will be charged to your card on file. Any balance on the account follows the office’s Financial Policy.

By signing below and initialing the following, I am agreeing to the broken appointment policy:

\_\_\_\_\_\_\_\_\_\_I understand that a broken appointment fee of $50 will be charged to my account if I fail to give at least 2 business days notice to cancel or reschedule my appointment.

\_\_\_\_\_\_\_\_\_\_I understand that for appointments scheduled for more than an hour a deposit may be required at the time of scheduling.

\_\_\_\_\_\_\_\_\_\_I consent to text reminders. (Fees may be incurred by your phone plan carrier.)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***INSURANCE AUTHORIZATION AND FINANCIAL CONSENT***

In order to meet the need of our patients, we have enrolled in various PPO insurance programs. As you can imagine, keeping up with all of the individual requirements for each of the insurance companies, which each of whom has 1,000s of different plans, can be practically impossible. Each program may have different requirements, stipulations, and frequency limitations that dictate which services can be provided and how often they can be provided.

It is possible that your insurance provider may NOT cover every service we provide in our office, and in these cases, you will be billed for the services provided. The insurance company may disallow treatment to improve their bottom line and are not looking out for your best interests. Many insurances still only cover silver fillings….something they don’t even teach in dental schools anymore! After all, the tallest buildings in downtown have insurance names at the top, not dentists. Insurance companies are not responsible for determining your dental health needs; dentists are. We take pride in how we treat our patients, explaining our findings, and the solutions for your dental health.

It is not our sole responsibility to know every detail of your particular insurance policy, but if we work together, both doing our parts to familiarize ourselves with your specific policy, we can focus on what we do best, take care of you. Please keep that in mind when we are presenting treatment plan estimates, until the insurance company actually makes payment it is *only an estimate*. We do our very best to give you an accurate “guesstimate.” It makes our lives a lot easier if we are correct as we don’t want to come back to you with a balance any more than you do.

By signing below and initialing on each line, you are agreeing to the following:

\_\_\_\_\_\_\_\_\_I hereby authorize my insurance company or any other third party payer to pay directly to Christina Boesch, DMD, P.A. all charges submitted for services incurred by me. I authorize use of this signature for all insurance submissions.

\_\_\_\_\_\_\_\_\_I accept responsibility for payment of dental services and understand that payment for these services, including deductibles and co-payments are due the day services are rendered. If you are unable to pay the day of service you maybe be charged a $50 fee for a “broken appointment”.

\_\_\_\_\_\_\_\_\_I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office ***I understand that I am responsible for payment and authorize this office to charge my credit card or bank account for any unpaid*** balances on treatment that I have consented to receive.

\_\_\_\_\_\_\_\_\_\_I approve charges of any remaining balance after insurance has paid to be charged to my credit card on file. An email will be sent with the date the charges will be run, giving you ample time to contact the office with any questions.

\_\_\_\_\_\_\_\_\_I understand and agree that I am responsible for payment of all charges on my account. If my insurance company fails to pay within sixty (60) days, I will be responsible for the full amount due.

\_\_\_\_\_\_\_\_\_I understand and agree that insurance benefit information presented is ***not a guarantee of payment*** by my insurance company, it is ***only an estimate*** based off my insurance information the office has been given. Therefore, I am responsible for any remaining outstanding balance after my insurance carrier has made payment or processed my claim.

\_\_\_\_\_\_\_\_\_I understand that accounts 30 days past due will incur a $5 per month late fee. Accounts over 120 days past due are turned over to a collection agency with additional fees.

\_\_\_\_\_\_\_\_\_I understand and agree that if collection action is to be taken to collect payment from me, I will be responsible for all if the costs of such action (collection agency and attorney’s fees included). There could be an additional 5% monthly finance charge for statements left with no response or payment. Prior to your account being submitted to collections your account is subject to 40% collection fee assessment. All statements are sent via Email.

\_\_\_\_\_\_\_\_\_I am consenting to communication through email. In an effort to be more environmentally friendly, we have eliminated paper billing. Please make sure that you have an accurate email address on file, to avoid missed emails and accounts being turned over to collections.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Credit Card Number Exp. Date CVC Code Zip Code

I understand and agree to the above stated office policies. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature of Patient, Parent or Guardian Date*