GRANTS FERRY
FAMILY DENTISTRY

Quality Care. Compassionate Approach.

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____ Preferred Name_____

Birth Date_____ SSN_____ ☐ Male ☐ Female Marital Status_____

Address_____ City_____ State_____ Zip_____

Phone Numbers: Home_____ Cell_____ Work_____

Email_____ Employer_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _____ Are you a current patient? ☐ Yes ☐ No

Relationship to patient _____ Phone Number:_____

INSURANCE INFORMATION

Policyholder's Name _____ Relation to patient _____

Policyholder's SSN _____ ID# _____ Date of Birth _____

Employer _____ Group Number _____

Employer's Address _____ Phone Number _____

Insurance Company _____ Phone Number _____

Mailing Address _____

SECONDARY INSURANCE ☐ Yes ☐ No Insurance Company _____

Policyholder's Name _____ Relation to patient _____

Policyholder's SSN _____ ID# _____ Date of Birth _____

Employer _____ Group # _____

Insurance Company _____ Phone Number _____

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CONSENT

- I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
- I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.
- I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).
- I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclose.

Signature:_____ Date:_____

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ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have without practice is to pay for treatment, regardless of the amount that may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance carrier. By having our office process your insurance forms, it is important that you understand that this does not eliminated your financial obligation for your treatment.

- We require you to sign this agreement and/ or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance carrier to make payment directly to our office.

- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.

- Insurance payments are usually made within 30-60 days from the date of service. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance on your account at that time. You will then be responsible for seeking reimbursement from your insurance company.

- Our office does not guarantee that your insurance company will pay for the treatment you receive from Dr. Green or staff. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time. Our treatment is not based upon your insurance coverage but upon providing you with comprehensive dental care which may require some out-of-pocket expenses.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation requested to settle any existing claims. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

- Returned checks are subject to a $30.00 service fee and all balances older than 90 days will be subject to collection action.

- **Broken appointments (no shows, or cancellations without 24 hour notice) are subject to a $25.00 fee for each hour of scheduled time reserved.**

- **I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.**

Patient Signature: _____

Date: _____