

THOMAS J. ENGLISH, DDS
PATIENT REGISTRATION AND CONSENT FORM

Today's Date _____

PATIENT INFORMATION (please print clearly with full detail)

Patient's Last Name: _____ Patient's First Name: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____
Street Address / Apt #: _____ City & State: _____ Zip: _____
If the guarantor, how would you like to be addressed? _____ Email address: _____
Home Phone #: (____) _____ Child Single Married Widowed Separated Divorced
Business Phone #: (____) _____ Patient's Employer: _____
Cell Phone #: (____) _____ Referred By: _____
Emergency Contact (Name and Phone #): _____

RESPONSIBLE PARTY INFORMATION (if different from Patient)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____
Street Address / Apt #: _____ City & State: _____ Zip: _____
Home Phone #: (____) _____ Relation to Patient: _____
Business Phone #: (____) _____ Cell Phone #: (____) _____

INSURANCE INFORMATION

Policy Holder Name: _____ Policy Holder Date of Birth: _____
Identification / Social Security #: _____ Group #: _____
Employer: _____ Insurance Company Name: _____ Phone #: _____
Street Address / Apt #: _____ City & State: _____ Zip: _____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act.

The patient / guarantor understands –

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

Patient/Guarantor initials to acknowledge.

ASSIGNMENT AND RELEASE

Your initials and signature acknowledges your understanding of the Privacy and Patient Consent sections of this form. Your signature also authorizes Thomas J. English, DDS to release dental information necessary to process your insurance claims (if any). You herein authorize payment of dental benefits to the dentist when an assigned claim is filed. "I authorize that any benefits due be paid directly to Thomas J. English, DDS. I also understand payment is expected at the time of service (all copays and balances due must be paid when the service is rendered)."

Patient Signature

Parent/Guardian Signature (if patient is a minor)

Date

OFFICE AND FINANCIAL POLICIES

Initial _____ **Payment for services is due at the time services are rendered. We accept Cash, Check, Debit cards, American Express, MasterCard, Visa, Discover, and CareCredit as forms of payment.** We are committed to providing you with the best possible care. If you have approved dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Initial _____ **INSURANCE: The patient is responsible for knowing their insurance benefit coverage and benefits.** As a courtesy to our patients, we will bill your primary insurance. Your insurance policy is a contract between you and your insurance company. As a health care provider we are not party to that agreement. Insurance policies vary and treatment may not be covered in full or may not even be covered at all. Our fees reflect our commitment to the quality of dentistry our patients deserve and are considered usual and customary for this area, regardless of any insurance company's determination of what they would like the fees to be.

We will **estimate** your portion for the services rendered for your visit. This amount is due and payable when services are rendered. If the insurance company pays less than the estimated portion, you are wholly responsible for the remaining balance.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are provided. We will allow 30 days, from the time your claim is submitted for insurance benefits to be paid. After that time, all charges are due and payable by you.

Initial _____ **SERVICE CHARGES:** A finance charge of 1.5% per month (18% APR) will be applied to all accounts 60 days or more past due. There is a \$25.00 fee for returned checks. Any fees incurred in the process of collecting payment are payable by the patient.

Initial _____ **NON-COVERED SERVICES:** In dental, there are many procedures that are considered by insurance companies as non-covered, including elective/cosmetic procedures. If you are coming in for a non-covered service, please be prepared to pay for the service in full when services are rendered. Procedures not covered by your insurance company will not be filed. A deposit may be required when any cosmetic procedure such as Zoom Whitening is performed. The deposit will be applied to your treatment cost, but may be forfeited if you NO SHOW or cancel less than 24 hours prior to treatment.

Initial _____ **NO SHOWS AND LATE CANCELLATIONS:** We require a 48-hour advance notice if you must cancel your appointment. As a courtesy, we will attempt to call and confirm your appointment 48 hours in advance. Ultimately it is your responsibility to remember your appointments. If you cancel on the same day as your appointment, you will be considered a NO SHOW for that visit. Each patient is allowed one NO SHOW penalty. The second NO SHOW may result in a \$50 charge to your account. Once you have two NO SHOW appointments in your file, you may also be required to secure any subsequent appointments with a credit card or you may also be subject to dismissal from the practice.

Initial _____ **MINORS:** The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for dental treatment signed by the parent or guardian before treatment can be rendered.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name: _____

DOB: _____

Responsible Person's Signature: _____

Date: _____