1842 Rye Road East, Bradenton FL 34212

941-253-2300

3Ddentistry.co

PATIENT INFORMATION

Patient Name:____

(Last) (First) (Middle initial)

Preferred Name:__________________________ DOB:_____________ Age:_____ Gender:___M ____F

Address:____

____

Email Address:____

Occupation:___________________________________ Phone:_______________________________________

Whom may we thank for your referral/How did you hear about our office?:_________________________

____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name:____

Phone:_____________________________ Relationship:____

Address:____

INSURANCE INFORMATION

Name of Policy Holder:____

(Last) (First) (Middle initial)

Relationship to patient: (spouse, parent, etc)__________________________ DOB:_________________

Insurance plan Name:__________________________ Insurance Phone#:_________________________

ID#:_____________________________ Group#:______________________________

FINANCIAL POLICY

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

As a courtesy to you, we will help you process all your insurance claims. Please understand that we provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We ask that you sign this form and/or any other necessary documents that may be required by you're your insurance company. This form instructs your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, which is the ESTIMATED amount, NOT covered by your insurance company at the time we provide the service to you.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental healthcare needs and welcome any questions you may have concerning your care or our financial policy.

___ I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the times services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any such number, without reimbursement from us.

Signature of patient, parent or guardian (responsible party):_________________________________

Relationship to patient:______________________________________ Date:___________________

Our office requires 24 business hours prior to cancellation. There will be a $50.00 per hour per provider fee charged to the patient for broken appointments.

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What does HIPAA involve: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. Providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the procedures utilized within the office for handling of charts, patient records, PHI and other documents of information.
2. We may place a courtesy call or send a courtesy text or e-mail to the phone number or email address you listed in your file in regards to your appointment. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products. Goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your PHI and to request change in certain polices used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**In general, the HIPAA privacy rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals' home.

Whom may we discuss treatment, payment and appointment information with? (ex; spouse, children relatives, friends caregiver)

Name:____

I do hereby consent and acknowledge my agreement set forth in the HIPPA Information Form and any subsequent change in office policy. I understand that this consent shall remain in force from this time forward.

Signature____ Date:______________________________