APPOINTMENT SCHEDULING POLICY

When you schedule an appointment in our office, we consider this appointment a reservation of chair time and expect that you will be recording this appointment date and time on you schedule. As a courtesy, we make every effort to remind patients of their appointment via postcard, email, text messaging, and phone. We do require that you respond to these calls by letting us know that you will attend your appointment. If we do not hear from you to confirm your appointment within 48 hrs of the scheduled time, we reserve the right to schedule another patient at that given date and time.

If you must change your appointment, we require at least 48 hour notice to avoid a possible cancellation fee. If commitments for appointments are frequently broken, a non-refundable reservation fee may be required to continue to schedule appointments in our office. When appointment times are lost due to last-minute cancellation, it delays your needed treatment and also prevents other patients from using that appointment time for their needed treatment.

Thank you in advance for respecting our scheduling polices. If you have any questions about scheduling, we would be glad to answer it.

FAMILY MEMBERS IN DENTAL TREATMENT ROOM POLICY

In order to provide the highest quality of care safely and efficiently to our dental patients, all family members and friends are required to remain in the waiting area while dental treatment services are being rendered. This policy will help our dental team ensure safety, infection control and patient confidentiality.

PARENT(S) OF MINOR CHILDREN

Experts in the field of pediatric dentistry universally agree that children are much more cooperative and attentive when parents are not present during dental treatment. In the event your presence is required in the dental operatory, you will be asked to join. With an especially resistant or frightened child, referral to a specialist might be necessary. Refusal to adhere to these policies could result in rescheduling until the parent feels that their child can handle routine dental care on their own.

I have read and understand the policies noted above for Pierpan Dental Excellence.

_____ _____

(Patient Signature) (Date)

Financial Policy

Welcome to Pierpan Dental Excellence. We are committed to providing you with best possible care. Our office hours are Tuesday - Friday, 8:00 a.m. to 5:00 p.m. All appointments are considered a reservation of the time set aside for you. We will do our utmost to schedule your visits at times that are convenient. We will assist you by giving you a courtesy call prior your appointment. In return we ask that you do the same and call to confirm all appointments to honor your reservation. Appointments that are unconfirmed within 48 hours prior the appointment may lead to cancellation.

Payment is expected at time of service. If you have insurance, we will accept assignment with most insurance companies after verification of coverage. You will be expected to pay your portion of services at the time of visit, including but not limited to, co-payments, percentages and deductibles. If for any reason your insurance denies a claim, the balance will be billed to you in full. In the situation of a divorce, the parent who signs the financial policy is the responsible party on the account regardless of who the insurance subscriber may be. We accept cash, checks, Care Credit, Mastercard, Visa and Discover. If you are unable to render payment at the time of service, we will be happy to reschedule your appointment or discuss financial arrangements prior being seated. We will estimate as closely as possible to your coverage, but until we actually receive payment from the insurance company, it is just an estimate. We will assist you in dealing with your insurance company, but ultimate responsibility lies with you. We do not file secondary insurances, but will assist you as much as we can in the process. After 45 days from the date of service, the balance will be due from you in full. If we are unable to verify coverage, you will be expected to pay for the visit in full.

If more than one family member is a patient, then they will be grouped under one account. If you wish to have a separate account from other family members, please notify the front desk upon signing this form. Family member can only be on separate accounts if they have separate insurance policies.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. At any time during treatment, we may contact a credit bureau with information regarding this account.

Returned checks will be charged $36.00. We will not attempt to redeposit more than once. Missed appointments, cancellations or reschedules with less than a 48 hour notice are subject to a $50.00 charge.

I have read the above policy, understand my responsibilities and agree to these terms.

Signed_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Patient Registration Form

Patient Name: _____
First M.I. Last

Social Security Number: _____ Driver's License: _____
Date of Birth: _____ Age: _____ Sex: M / F
Marital Status: Married Single Divorced Separated Widowed

Address: _____
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Work Phone: (_____)_____-_____ Email Address: _____
What is the best way to contact you? _____
Sign if you would like to receive text messages (Standard Fees may apply):
_____

Employment Status (Please circle one): Full time Part time Retired Student
Employer Name: _____ Employer's Phone Number: (_____)_____-_____
Employer's Address: _____

Primary Care Physician: _____
Phone Number: (_____)_____-_____
How did you hear about the practice?
_____

Person Responsible for bill or parent (Complete only if different from the patient)
Guarantor Name: _____ Social Security Number: _____
Relationship to patient (please circle one): Self Spouse Parent Date of birth: _____
Address_____
Phone Number: _____
Employer Name: _____ Employer's Phone Number: (_____)_____-_____
Employer's Address: _____

Who to call for an emergency
Name: _____
Address: _____
Home Phone: (_____)_____-_____Cell Phone: (_____)_____-_____
Work Number: (_____)_____-_____ Relationship: _____

Primary Insurance Information
Plan Name: _____ I.D. Number: _____
Address: _____
Phone Number: (_____)_____-_____ Effective Date: _____
Policy Holder: _____
Policy Holder's Social Security Number: _____
Policy Holder's Date of Birth: _____ Sex: M / F