Dr. David Powell
All Care Dentistry

Patient's Name_____ Birthdate_____ Age_____
Address_____ City_____ Zip Code_____
Sex: **M**____ **F**____ Social Security #_____ Marital Status: M___ S___ W___ D___
Cell Phone # _____ Work Phone # _____
Email Address _____
Patient Employer _____
Emergency Contact _____ Relationship _____
Emergency Contact #_____ Referred By _____

INSURED PERSON INFORMATION

Name of Insured Person_____ Relationship to Patient _____
Cell Phone# _____ Social Security # _____
Date of Birth _____ Insurance Company _____
Subscriber ID _____ Group # _____
Secondary Insured Person_____ Relationship to Patient _____
Date of Birth _____ Insurance Company _____

PRIVACY POLICY

In consideration for professional services rendered to me, or my minor child or ward, I agree to pay the fees charged for the dental services provided by the dentist or his team members at the time the service is/are rendered. I also authorize my Insurance Company to make payment directly to the dentist for services rendered and agree to pay any uncovered balance.

I grant my permission to the dentist/team/office personnel to use any form of communication, at home or work, to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine, email, text message, or with a family member.

I authorize the dentist/team/office personnel to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier, or any related entities that require such information to be submitted.

This agreement supersedes all prior agreements signed, including any and all mediation or arbitration agreements. I acknowledge any prior mediation or arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I acknowledge I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist the names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on any and all forms generated by this office to the best of my ability. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent, Guardian **Date**

INSURANCE AND FINANCIAL POLICY

We desire to provide dental care for you and to work with any insurance coverage you may have and that we accept. Our practice depends upon reimbursement from patients to cover operating expenses and maintain viability. Therefore, as a condition of your treatment in our office, financial responsibility must be determined and certain payments made before treatment begins.

1._____ Professional services are rendered to the patient, not to the Insurance Company. Therefore, the Insurance Company is responsible to the patient and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid by an Insurance Company. Our office will help prepare insurance forms, assist in making collections from Insurance Companies, and will credit any such collections received to the patient's account. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service.

2._____ Unfortunately, insurance benefits often do not cover the total cost of your treatment. Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the Insurance Company. We are unable to increase benefits beyond that which your insurance agreement allows. However, this should not govern what is in your best interests as far as treatment is concerned.

3._____ For your convenience, we will ESTIMATE the amount of your total fee that your Insurance Company WILL NOT cover. This is JUST AN ESTIMATE. After your Insurance Company pays your insurance benefit, you are responsible for ANY UNPAID BALANCE. We will ask you to pay the ESTIMATED uncovered amount at the time of treatment. Co-payments, as per your insurance contract, are also due at the time of service. For larger treatment plans, payment may be required prior to scheduling.

4. _____ The fee estimate for any diagnosed treatment is valid for six months from the last examination date.

5._____ We can pre-authorize your insurance benefits. However, this sometimes delays treatment 4-6 weeks if your Insurance Company is slow to respond. A lengthy delay in treatment may not be in the best interest of your health.

6. _____ Appointment cancelled less than 24 hours before the appointed time, or appointments missed completely, may be subject to a $75 per hour charge, based on the length of the allotted appointed time.

7. _____ Should collections become necessary, the responsive party agrees to pay an additional 40% collection fee, and all legal fees associated with collection, with or without suit, including attorney fees and court costs.

8. _____ Cash, check, Visa, Mastercard, Discover and American Express credit cards are acceptable forms of payment. We also accept HSA and FSA cards.

Signature of Patient, Parent, Guardian **Date**