



### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Insurance Information

**Primary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ Last First MI ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

**Secondary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ Last First MI ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

**Health Insurance Portability Accountability Act (HIPAA), 1996**

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

**SECTION A: PATIENT/GUARDIAN GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Bradley Park Family Dentistry**

**4 Bradley Park Ct. Columbus, GA 31906**

**(706)507-0606**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE:** \_\_\_\_\_ **Date** \_\_\_\_\_

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.**

## Acknowledgement of Receipt

### ***Notice of Privacy Practices***

**Purpose:** This form is used to obtain acknowledgement that you have been notified that our **NOTICE OF PRACTICE POLICIES** can be obtained via our office. This document is printable via the web-site for your records.

HIPAA web-site: <http://www.hhs.gov/ocr/hipaa/finalreg.html>

**\* You May Refuse to Sign This Acknowledgement\***

I, \_\_\_\_\_, have received acknowledgement of this office's Notice of Privacy Practices.

\_\_\_\_\_ date

Signature

#### **For Office Use**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
-

# Bradley Park Family Dentistry

## Financial Policy

### Financial Policy:

Payment is expected at the time of service unless previous arrangements have been made. We accept cash, checks and all major credit cards. If you have questions about the fees for services you are to receive just ask and we will be glad to help you.

### Insurance Policy:

For our patients who have insurance to help with the cost of their dentistry, we offer the convenience of filing your claims for you. Please present us with your current dental insurance card at the beginning of your appointment. We are a participating in-network provider with most dental insurance plans. We are glad to offer this service to you and help you in any way possible. In this regard we would like to offer the following tips:

1. **Know your plan.** If you have questions regarding what your insurance will cover, call the number on your card and ask that your benefits be explained to you. The more you know the less likely it is that you will receive an unexpected bill.
2. Call your insurance company or ask at the front desk, prior to your appointment, what your estimated co-payment will be. We reach this amount based on the information your insurance company gives us. It is only an estimate.
3. Your co-payment is expected at the time of service. You are responsible for any amount not covered by your plan.

I have read and agree to comply with the above financial policy as it applies to my dental treatment:

Print: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

We respect your time and ask that you respect ours as well:

**We reserve the right to charge a \$75 missed appointment fee for appointments canceled with less than 24 hours notice.**

Sign: \_\_\_\_\_ Date: \_\_\_\_\_