THE RIGHT SMILE CENTER LLC

WELCOME and we appreciate you choosing our office for your dental needs. The following information will be held in compliance with the applicable HIPAA laws.

PATIENT INFORMATION

Patient's Name _____ (M F) Married Single Divorced Widowed
Birth Date _____ Social Security # _____
E-mail Address _____ Cell Phone _____
Home Address _____ Apt # _____
City_____ State_____ Zip _____
Home Phone _____ Dental Insurance (Y N)
Spouse's Name _____Contact # _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Last Name _____ First _____ MI _____

Birth Date _____ Social Security # _____

Relationship to Patient _____ Work Phone _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Home Address _____ Apt # _____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

EMERGENCY/CONSENT TO INFORMATION

I understand that by signing this consent form I am allowing my medical information to be released in the event of an emergency or upon request by:

Closest relation not living with you, _____Phone _____
Address _____City _____State _____Zip _____

PATIENT / GUARDIAN SIGNATURE _____Date _____

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CHILDREN ACCOUNTS

If the patient is under 18 years old, please complete the following. Please be aware that the parent/guardian of the minor patient is responsible for the account. We are unable to bill a parent who is not present at the appointment.

Parent/Guardian _____ Minor's Relationship _____

Date of Birth _____ Social Security # _____

Home Phone _____ Cell Phone _____
Email Address _____
Employer _____ Work Phone _____
Employer Address _____
City _____ State _____ Zip _____

I authorize the dental staff to perform the necessary dental services my child may need:

_____ _____
Signature of Parent or Guardian Date

DENTAL INSURANCE INFORMATION& ASSIGNMENT OF BENEFITS

Primary Insured _____

Employer _____

Birth Date _____ Social Security # _____

Group # _____ ID # _____

Insurance Carrier _____ Effective Date _____

Insurance Carrier's Phone # _____

Claims Address _____
City _____ State _____ Zip _____
Others Covered _____
Secondary carrier/dental insurance plan? _____/Carrier _____

We accept the assignment of your insurance benefits directly to our office subject to verification of coverage. We make **best estimate** patient portion benefits based on the information provided by your carrier but **we are unable guarantee your insurance coverage**. All treatment coverage is subject to carrier review. **Our office will make best efforts on your behalf but will not enter into a dispute with an insurance company over claims or coverage**. Our PAI Coordinator will be happy to provide best estimate coverage before your initial treatment.

I understand the practice's policy, and assign directly to Novy Scheinfeld, D.D.S., P.C., all benefits that would be payable to me for dental services rendered. I hereby authorize this office to use this signature on all of my insurance submissions and allow the release of any information necessary to secure the payment of benefits. I understand that I am responsible for any amounts not paid by my insurance company within 60 days. Any payments received directly by me from my insurance carrier for dental services I agree to notify and deliver to Novy Scheinfeld, D.D.S., P.C., within 10 days of receipt.

PATIENT / GUARDIAN SIGNATURE _____ Date _____

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FINANCIAL INFORMATION

Thank you for choosing our office for your dental needs. Professional services are rendered and charged to the responsible party. We will be happy to work with you in planning treatment to fit your financial needs. We reserve the right to ask that you pay in full for treatment on the day that services are performed, If you should need extensive dental treatment, we gladly offer extended payment plans but arrangements must be made with our Financial Coordinator in advance of treatment. For your convenience, we accept cash, checks ($30.00 fee for returned checks), and VISA/MasterCard/AMEX/Discover as payment. We will consider all accounts that are over 30 days subject to a $15.00 billing fee or 1.5% of the balance service charge (whichever is greater).

For our patients who have dental insurance, your estimated portion will be due on the day of treatment, and we **never guarantee** an exact amount that your insurance carrier will pay. You will be responsible for any remaining amount not covered by your insurance carrier including: deductibles, co-payments, services or charges denied by the carrier, or amounts over your carrier's allowances. The amounts you are charged or reimbursed are subject to change at the discretion of your insurance company and do not affect the amount due for services rendered. Also, we reserve the right to request and you agree to pay any claim not processed by your insurance company within 60 days. As a courtesy to you we try to give you notice after your amount due is outstanding for 45 days.

Please sign below that you have read and understand the above financial procedures and agree to all of the terms. If you have any questions please speak to our PAI Coordinator prior to your appointment.

PATIENT/ GUARDIAN SIGNATURE _____ Date _____

EXTENDED PAYMENT

A third-party organization is available to provide financing to patients for dental treatment. A patient must qualify for this type of arrangement. Applications are available in this office. Please feel free to ask for one.

YOUR PRIVACY

Your privacy is assured in our office and your health records require your written consent to be released. Along with your forms you have been afforded access to our Privacy Policies as required by the HIPAA Privacy Act (proposed by the US Department of Health and Human Services-effective April 1, 2003). Please sign this so we know you have received a copy of our privacy practices.

PATIENT/ GUARDIAN SIGNATURE _____ Date _____

PHOTOGRAPHY RELEASE

I authorize the office of Novy Scheinfeld, DDS to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that if any of these are used in any educational purposes, as a part of a demonstration, or advertisement, my name or any other identifiable information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photographs.

PATIENT/ GUARDIAN SIGNATURE _____ Date _____

BROKEN APPOINTMENT POLICY

Please consider your scheduled appointments carefully. We ask for at least a 72-hour notice of cancellation. If we do not receive a 48-hour cancellation notice, we charge you $50.00 for the scheduled time. We are here for you and allocate our staff and office resources to serve you. If you cancel without proper notice, we know you understand that we may not be able to fill your appointment with another patient and we are still responsible for the staff and office resource costs incurred. This cannot be charged to your insurance company. If you repeatedly miss scheduled appointments, you may be asked to pursue treatment on non-scheduled time, as available.

PATIENT/ GUARDIAN SIGNATURE _____ Date _____