Mansfield Periodontics • 100 Copeland Drive Suite 3 • Mansfield MA 02048 • (508) 543-9292

Patient Information

Patient Name: _____ Date: _____
LAST FIRST MI (PREFERRRED)

Gender: □ Female □ Male □ Married □ Single □ Child □ Other

Social Security #: _____ Birth Date: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Phone (Home): _____ (Work): _____ (Cell): _____

Email: _____ Pharmacy/Location: _____

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____
STREET CITY STATE ZIP

Health Information

Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

□Allergies: _____
_____
_____
_____

□ AIDS/HIV
□ Anemia
□ Angina
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness/Fainting
□ Epilepsy/Seizures
□ Excessive Bleeding
□ Glaucoma
□ Growths or Tumors
□ Hay Fever
□ Head Injuries
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Hepatitis
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease/Jaundice
□ Mental Disorders
□ Nervous Disorders
□ Pacemaker
□ Phen-Fen Usage
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sex. Transmitted Dissease
□ Osteoporosis/Bisphosphonate
□ Sinus Problems
□ Smoking/Tobacco Use
□ Steroids
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Thyroid Problems
□ High Cholesterol
□ Current Medications:
_____
_____
_____
□ OTHER:
_____

□ Yes, □ No: Have you been admitted to a hospital or needed emergency care during the past two years?

□ Yes, □ No: Are you now under the care of a physician?
Name of Physician: _____ Phone #: _____

□ Yes, □ No: Are you pregnant or is there a possibility you may be pregnant?

□ Yes, □ No: Do you have any concerns that you would like to discuss with the doctor privately?

□ Yes, □ No: Have you ever had any complications following dental treatment?

□ Yes, □ No: Do you grind your teeth?

□ Yes, □ No: Do your jaw joints ever click, pop, or give you pain?

□ Yes, □ No: Have you ever had periodontal treatment in the past?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?
□Dental Office: _____ □Other: _____

FOR OFFICE USE ONLY

Doctor's Signature: _____

Insured or Responsible Party Information

The following is for: ***□The person responsible for payment*** ***□The insurance subscriber***

Name: _____
LAST FIRST MI

Gender: □ Female □ Male □ Married □ Single □ Other

Social Security #: _____ Birth Date: _____ Employer: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Phone (Home): _____ (Work): _____ (Cell): _____

Notice of Privacy Practices

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

Please inform us if you require more information regarding our policy or if you would like a complete copy of our Privacy Practices.

Uses and Disclosure of Health Information:

***Treatment** ***Your Authorization** ***Marketing Health-Related Services** ***National Security**
***Payment** ***Required By Law** ***To Your Family and Friends** ***Appointment Reminder**
***Abuse or Neglect** ***Healthcare Operations** ***Persons Involved In Your Care**

Acknowledgement of Receipt of Office Privacy Practices

I, _____ have reviewed a copy of this office's Notice of Privacy Practices.

_____ Date: _____ Relationship to Patient: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

For Office Use Only: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: □ Individual refused to sign □ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement □ Other (Please Specify): _____

Consent for Services

I hereby give consent for the doctor and staff to perform such diagnostic, photographic, and therapeutic procedures as may be necessary on me or my child. As a condition of your treatment by this office, payment is due at the time of service. 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.

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 patient's 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.

Missed appointments will be charged at the rate of a normal office visit, unless cancelled **48 hours in advance**.

A rebilling fee of $20 per month on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial agreements are satisfied. A fee of $150 will be added to accounts that are referred to a collection agency in addition to court costs and attorney's fees.

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 her assignee, at the time said services are rendered, or within five 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 were instituted hereunder. **You are entitled to a copy of this form.**

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.

_____ Date: _____ Relationship: _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____ Date: _____ Relationship: _____

SIGNATURE OF GUARANTOR OF PAYMENT/RESPONSIBLE PART

EXPLANATION OF DENTAL INSURANCE AND DENTAL PLANS

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We are pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits, so with this in mind, please read the information regarding our policy on dental insurance benefits.

DO YOU ACCEPT MY INSURANCE?

If your insurance plan allows you the freedom to choose your own doctor, then you can use your benefits in our office. We are happy to file your claim for you, and will accept the assignment of benefits if your plan allows. Accepting assignment of benefits does not mean that we accept whatever the insurance company pays as full payment. Most insurance plans require the patient to pay a deductible and a portion of the bill.

HOW MUCH WILL THEY PAY?

Once we have the opportunity to verify your dental insurance coverage and obtain an approximate breakdown of benefits, we are able to estimate your payment portion based on the information we receive, but it is **ONLY AN ESTIMATE**. Please understand that we do not have a contract with every insurance company; therefore it is impossible to give you a guarantee of what the insurance company will pay at the time of service. **If we are unable to verify your insurance coverage, you are responsible for payment in full of all fees associated with your treatment at each visit.**

If you want to determine what your insurance will pay, we are happy to file a pre-treatment authorization with your insurance company prior to treatment. This may take up to several weeks, but will give you the exact out of pocket figure you require.

INSURANCE DIDN'T PAY NOW WHAT?

Ultimately, you are responsible for all charges incurred in our office. We file your primary insurance claim as a courtesy to you. We do not file for secondary insurance. Some procedures performed in our office *may* be covered by your medical insurance; we do not file this for you. We will provide you with an itemized statement of procedures performed. It is important that you recognize the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not, and cannot be a part of that legal contract. If your insurance company does not pay a claim within 60 days, Mansfield Periodontics and Dental Implants, PLLC reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. Additionally, dental insurance is designed to defray the cost of your dental treatment. It is not intended as a total payment for services and should not be used to determine the type of amount of treatment you receive.

I THOUGHT I PAID MY PORTION BUT I STILL OWE MORE, WHY?

We base your estimated out of pocket expense on the benefit verification information we receive form your insurance company, but there many factors that can affect this estimate. There may be an annual deductible that must be met (individual or family), or you may have received treatment in another office. Further, insurance companies do not (and cannot in most cases) notify our practice of changes to your benefits, they only notify you. If any of these situations apply to you, please let us know as soon as possible.

WHAT IS UCR?

UCR stands for Usual, Customary, and Reasonable. It is a term created by insurance companies to define what they are willing to pay for a particular procedure.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay the office of Dr. Valerie Smith to all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claim submissions.

I authorize the office of Dr. Smith to release all information necessary to secure payment of insurance benefits.

I understand that I am financially responsible for all fees regardless of whether or not they are covered by insurance.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment.

Patient/Parent/Guardian Signature_____Date _____

Financial Policy

Updated 10/16/2023

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Thank you for selecting us as your dental care provider. The following information describes our financial policy. Our primary goal is that you receive the optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies please do not hesitate to ask one of our staff members.

Payments for services rendered are due at time of treatment. We accept cash, personal checks, Visa, MasterCard, Discover, and American Express. We will help you process your insurance claim for your reimbursement as long as we have all of your insurance information. **However, you will be required to pay the portion of the service that we estimate will not be paid by the insurance company.**

1. Your insurance policy is a contract between you, your employer, and the insurance company. Our financial relationship is with you, not your insurance company.

2. All charges are your responsibility whether or not your insurance company pays. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. Fees for these services, along with unpaid deductibles and co-payments, are due at time of treatment. **We will collect the expected patient portion at the time of service.**

4. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to assist with payment in a timely fashion.

5. If the insurance company does not pay in full within 60 days, we will require you to pay the balance in full with cash, personal check, Visa, MasterCard, Discover, or American Express.

6. Balance older than 30 days will be subject to $20.00 per statement rebilling fee. Returned checks will have a fee of $35 added to your balance.

7. If it becomes necessary, at our discretion, to turn an overdue balance over to collection, you will be responsible for a collection fee of 1/3 of your delinquent account.

8. You authorize us, our successors or assigns, to call you or send a text message to you at any number you provide or at any number at which we reasonably believe we can contact you, including calls to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1) suspected fraud or identity theft; (2) obtaining information necessary or desirable; (3)your account transactions or servicing; and (4) collecting on your Account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns. You agree to pay any fee(s) or charge(s) that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us**.**

_____(Initials) *Please note that, unless cancelled at least 48 hours in advance, you will be charged for the visit (We do not accept cancellations on voicemail or email). For Monday appointments, we request notification prior to the close of business on Friday. Please call the office as soon as possible if you have to reschedule. Cancellations affect many people, including you (your dental health), the doctor and staff, and the patient(s) who could have been scheduled, and they increase the cost of care.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing our office as your dental care provider. We appreciate your confidence and the opportunity to serve you.

SIGNATURE _____DATE _____

Please let us know if you would like a copy of our financial policy.