McOmie Family Dentistry
PATIENT REGISTRATION

Patient Information:

First Name: _____ Last :_____MI: _____
E-Mail Address: _____ Preferred Name: _____
Birth date: _____SS#:_____
Address: _____Apt #:_____ City:_____
State:_____ Zip_____ Home phone _____Work#_____
Cell phone #:_____ Referred By:_____

Responsible Party:

(If the patient is younger than 18 years old)
First Name: _____ Last Name:_____ MI:_____
Birth date:_____ SS#:_____
Address:_____ Apt#:_____ City:_____
State:_____ Zip:_____ Cell phone #: _____

Dental Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits, but we can NOT guarantee payment from them. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year. (Your insurance year may not run January-December)

If your insurance has not paid within 60 days of services rendered, you will need to make full payment to this office. You will be reimbursed when your insurance company pays. After 60 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured, and/or the employer through whom the policy was purchased, has a better ability to deal with the insurance company, as they are the client of the insurance company.

Policy Holder: _____ Insurance Company: _____
Policy Holder DOB: _____ Policy Holder SS#: _____
Group #: _____
Claims Address & Phone Number_____
ID #: _____ Employer: _____

X _____
Signature of patient or parent if minor Date

Authorization/Release Information:

Information release: I have reviewed the treatment plan and I authorize the release of any information relating to this claim including x-rays, study models, photographs.
I hereby authorize release of any information to the following listed below:

X_____ **X**_____

X _____
Signature of patient or parent if minor Date

Financial Responsibility:

Fees for professional services are charged directly to the patient and the patient is personally responsible for payment. We will prepare necessary forms to assist in obtaining your insurance benefits. We do not render our services on the basis that insurance companies will pay our fees.

I understand that I am responsible for all charges that may be incurred and that if I fail to pay the balance due within 30 days of billing, a late charge of 1.5% per month (18% per year) may be added (if allowed by law). Fees will be charged for any un-kept appointments and appointments canceled without 24 hours advanced notice.

I understand that if I fail to keep this account current, we may be unable to provide additional dental services, except for dental emergencies or when I prepay for additional services. If I default on payment, I agree to pay all fees associated with collection of the outstanding balance, including but not limited to, attorneys fees and court costs.

X _____

Signature of patient or parent if minor Date

Appointments:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a 24 hour notice for any canceled appointment. It is our policy to charge a missed appointment fee of $60 after the second missed or canceled appointment.

X _____

Signature of patient or parent if minor Date

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what is commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form.

ACKNOWLEDGMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative
Authority of Personal Representative to Sign for Patient (check one):
□ Parent □ Guardian □ Power of Attorney □ Other

Please Note: It is your right to refuse to sign this Acknowledgment.
If patient refuses acknowledgment dental office staff must sign._____