

REGISTRATION, FINANCIAL POLICY, AND CONSENT FOR PATIENTS WITH DENTAL INSURANCE-NORTH CENTRAL ENDODONTICS

REGISTRATION FORM

Name _____ Date _____

Address _____
Street City State Zip Code

Home Phone # _____ Day Time Phone # _____ Cell Phone # _____

Date of Birth _____ Who is your regular dentist? _____

Occupation _____ Male Female Marital Status _____ E-mail address _____

FINANCIAL POLICY

Based on the information we have received, the estimated cost of treatment is:

Consultation \$ _____ Your estimated portion to pay \$ _____

Cone Beam Scan \$ _____ Your estimated portion to pay \$ _____

Root Canal Treatment \$ _____ Your estimated portion to pay \$ _____

Root Canal Re-treatment \$ _____ Your estimated portion to pay \$ _____

Surgical Root Canal Therapy \$ _____ Your estimated portion to pay \$ _____

**Fees are subject to change without notice. Failure to cancel appointments within 48 hours, will result in a \$50.00 fee.
Any Monday appointments must be cancelled by 3 pm the Thursday prior**

PATIENTS WITH DENTAL BENEFITS

As a service to you, we will electronically file the necessary claim form to your insurance company. You are responsible for the accuracy and completeness of the information that you provide to us. You are responsible for any portion of treatment not covered by your insurance plan. We will make every effort to contact your insurance company to estimate your insurance benefit.

The estimated Co-payment is due on the day of service. Please allow 2-4 weeks for your insurance company to process your insurance claim. If your insurance company has not paid your benefit in 60 days, after the claim has been filed, your account is due in full. A 1.5% per month billing fee will be added to all accounts after 60 days from the date of service. Prompt adjustments for any difference in the estimated benefit and the actual benefit will be made when we receive the explanation of benefits (EOB) from your insurance company.

Payment Options: (Please check your payment preference)

___ 1. Cash or Check ___ 2. Credit Card (Master-card, Visa, Discover) ___ 3. Care Credit (carecredit.com)
(6 months-no interest financing)

Please initial _____ I have read this policy. I understand it and agree to its terms.

A parent or guardian must accompany patients who are minors. This person must be qualified to provide legal consent and be financially responsible for payment.

Are you an active duty member or veteran of the United States Armed Forces? Yes or No

PLEASE COMPLETE OTHER SIDE

North Central Endodontics- WISCONSIN CONSENT

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to Dr. Schmidt of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

Date _____

HIPAA

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
AND**

CONSENT / AUTHORIZATION / RELEASE FORM

We cannot process your insurance claims if you refuse to sign this acknowledgment/authorization.

The undersigned acknowledges receipt of a copy of this healthcare facility's currently effective Notice of Privacy Practices. A copy of this document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A RECORDS RELEASE
SHOULD I REQUEST THEY BE SENT TO OTHER DOCTORS / PRACTICES**

Please *print the* name of Patient

Signature of Patient, or Guardian of Patient

Date _____

Please print name of Guardian/Legal Representative and Relationship

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO

☐ **CONFIRM MY APPOINTMENTS, TREATMENT, HEALTH, or BILLING INFORMATION**