REGISTRATION, FINANCIAL POLICY, AND CONSENT FOR PATIENTS WITHOUT 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 $_____

Cone Bean Scan $_____

Root Canal Treatment $_____

Root Canal Re-treatment $_____

Surgical Root Canal Therapy $_____

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

Payment is due in full at the time of treatment for all patients. For your convenience we offer three payment options: Please check your payment preference.

___ 1. Cash or Check (5% discount) ___ 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 that 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_____

HIPPA

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