

Financial Policy and Agreement and Cancellation Policy

The goal of DENTISTE is to provide exceptional customer service and excellent dental care with both a professional and personal touch. We want to make certain that our financial policies are clear and understood by you.

If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount **up to** 60 days. We will file the appropriate claim forms with your insurance company, provided that you provide us with your personal information including social security number and date of birth. We will also assist you in understanding your dental plan benefits.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from the date services are rendered, the amount will then become due and payable by you. Please remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot guarantee your insurer will pay.

Your payment is due at time of service

Fees for treatment are due at the time treatment is rendered after deduction of your good faith estimate of insurance benefits as described above.

Payment options: Cash, Check, Check Card with Visa logo, Visa and MasterCard

Patient Responsibility

I acknowledge my responsibility for payment of services rendered by DENTISTE in accordance with DENTISTE fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on your account is not paid within 30 days of statement, your account will become delinquent and will be forwarded to a third party collection agency. If this becomes necessary additional fees may be added to cover handling charges.

Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with DENTISTE.

Cancellation Policy

At DENTISTE, we recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice.

We are committed to seeing our patients on time and respecting their time. Late cancellations (less than 48 hours notice) failed appointments, and late arrivals are disruptive to our schedule and other patients.

In order to maintain our schedule we request 48 hours notice for cancellations or rescheduling of appointments. In the instance of a late cancellation (less than 24 hours notice) or a failed appointment there may be an \$80.00 charge per hour of scheduled appointment.

DENTISTE | Kate McKinney DDS

**Acknowledgement of Receipt of
Statement of Privacy Practices/Cancellation Policy**

I acknowledge that I have received a copy of the Statement of Privacy Practices and Cancellation policy for the offices of Kate McKinney, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Kate McKinney, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Name of Patient or Personal Representative:

Signature of Patient or Personal Representative: _____

Date:

ADDITIONAL DISCLOSURE AUTHORITY & EMERGENCY CONTACT

In addition to the allowable disclosures described in the Statement of Privacy Practices, in the event of an emergency, I hereby specifically authorize disclosure of my healthcare information to the persons indicated below.

Name(s): _____

Contact Phone Number: _____

Patient Name:

Date:

Patient Signature: _____

MEDICAL HISTORY

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thanks you for answering the following questions.

Are you under a physician's care now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	If yes, describe: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Do you use controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? In or past menopause?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Pace Maker*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea		<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No N/A _____

Current Medications: _____

Comments: _____

Do you like your smile? _____

If you could change anything about your teeth, what would it be? _____

*Condition may require Medication

N/A – Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE: November 8, 2005