TOWN SQUARE
DENTAL CARE

Today's Date: _____

FINANCIAL AND SCHEDULING POLICIES

This agreement is between Town Square Dental Care, PC as creditor and the patient/guarantor named on this form.

Payment/Insurance:
We require all patients to pay at time of service. We do not arrange payment plans. We will gladly submit your insurance claims and assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and do not cover 100% of all our fees. Your contract with your insurance company requires you pay all applicable co-pays and deductibles. These fees must be paid to Town Square Dental Care at the time of service.

It is your responsibility to know the requirements of your insurance company. This includes, but is not limited to: deductibles, co-pays, limitations, maximum benefits, waiting periods, pre-existing conditions and prior approval. Insurance contracts vary from company to company, patient to patient; **so, we are unable to communicate all the details of your insurance plan with you.** You may speak directly with your insurance company or your employer for this information.

Your insurance plan is based on a contract between your employer or a benefit group. It is not based on your individual dental needs. You are responsible for all charges your insurance does not cover.

Divorce:
In the case of divorce or separation, the parent authorizing treatment for a minor will be the person responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent. WE WILL NOT collect from them.

Past Due Accounts:
We will take necessary steps to collect any debt by means of a collection agency or attorney. If a patient refuses to pay charges, they may not be able to continue as a patient in this dental office.

Scheduling:
Every effort will be made to schedule your appointments at times that work for you. As a result, we ask you show up to your appointments on time. If you need to reschedule an appointment, please give us 24-hour notice to do so. If a patient repeatedly misses appointments without providing proper notice, we may discontinue scheduling them at this office.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Patient's Name: _____

Responsible Party Signature:
_____

TOWN SQUARE
DENTAL CARE

Today's Date: _____

INSURANCE AND HIPAA POLICIES

Primary Insurance:
Subscriber/Policy Holder: _____ SSN: _____ Birth Date: ____/_____/____
Patient's Relationship to the Subscriber/Policy holder:
_____
Insurance ID #: _____ Group ID #:
_____
Employer: _____ Insurance Company:
_____

Secondary Insurance:
Subscriber/Policy Holder: _____ SSN: _____ Birth Date: ____/_____/____
Patient's Relationship to the Subscriber/Policy holder:
_____
Insurance ID #: _____ Group ID #:
_____
Employer: _____ Insurance Company:
_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____
{Signature}

_____
{Date}

If patient is minor or dependent:

_____ Guardian Name

_____ Relationship to Patient

_____ Date

Information may also be released to:

Name: **Relationship**

_____ _____

TOWN SQUARE
DENTAL CARE

Today's Date: _____

_____ _____

_____ _____