ARCH DENTAL of WOODBURY, PC (516) 921-8010
800 Woodbury Road, Suite D, Woodbury, NY 11797 www.archdentalwoodbury.com

Financial and Insurance Agreement

Welcome to our office. We are honored that you have chosen us as your dental health care provider.
Quality dental care is a financial investment. If you have insurance benefits, we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. Your contract for insurance benefits exists between you and your insurance carrier.

Please remember that you are ultimately responsible for your account with our office.

1. We accept payment for services by cash, check, MasterCard® , Visa® , and American Express® .

2. If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.

3. If your insurance does not cover 100 percent of the charges, you may be billed the balance amount. You will receive an estimate of your liability prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office.

4. When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated copayment and deductible be paid at the time of service. We may require a deposit at the time of appointment for some services that cost more than $200. Our office will let you know of any required deposit in advance. We will file insurance claims and accept assignment of benefits. After receiving payment through your insurance, we will send a statement with any balances due or credits. We ask that payment be made within 14 days of the statement. In the event of a credit, we will promptly issue a refund. In the event that your insurance does not pay within 45 days, we ask that you make payment in full and contact your insurance company regarding reimbursement to you.

5. If you do not have insurance, your insurance pays you, or you are over your insurance limit, payment in full is expected at the time of service unless arrangements have been made in writing prior to treatment.

6. In cases of extensive treatment for which full payment cannot be made at the initial appointment, a financial arrangement may be reached. Documentation of this arrangement should be signed by the patient and office staff.

7. Fees quoted will be accepted for 30 days. In the event that clinical conditions warrant a different treatment, you will be notified of changes prior to the procedure.

8. In the event of default of payment or after 90 days, a service charge of 1.5 percent per month or 18 percent annually will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings.

9. Our office requires a 24-hour notice for any canceled appointments. A fee of $150 may be assessed for canceling an appointment without 24-hour notice.

10. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

11. No refunds will be issued once treatment plan has been approved and commenced.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask—we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Patient signature: _____ Date: _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of **(Patient)**_____dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice of fully outlining the protection of my personal health information.
5. I also authorize the doctor to use anonymized photographs, videos, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, scientific publications and marketing.
6. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient to follow post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
7. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I, therefore, authorize and request the performances of any additional procedures that are deemed necessary for desirable oral health and well-being, in the professional judgment of the dentist.
8. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed upon dates, I understand that a 1-1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
9. Cell phone: I consent to the dental practice using my cell phone number to (choose one or both) call or C] text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.
10. My cell phone number is (include area code) _____
11. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided an answer to the questions which may arise during and after the course of my treatment.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect / / and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our practices or for additional copies of this notice please contact us using this information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENTS: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of health care professionals, evaluating practitioners and provider performance conducting training programs accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment payment or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose you health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you as described in this patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of including identifying or locating a family member your personal representative or another person responsible for you care of you location your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reason able inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIERED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Patient Demographics and Insurance Information

***(if this appointment is for you, please complete the following)**

Last Name **First** **MI**

Preferred Name

Date of Birth (MM/DD/YYYY) **Age** **Gender (M/F)**

Married **Single** **Divorced** **Widowed**

Social Security Number

Address (Street, Apt.)

City, State, Zip

Home Phone Number **Cell**

Email

Emergency Contact **Relationship** **Home Tele No.** **Cell**

Is another member of your family, relative or friend a patient of our practice?

Name **Relationship**

Name of Referral (who can we thank for their trust and confidence)

***(if this appointment is for your child, please complete the following if different from above)**

Last Name **First** **MI**

Preferred Name

Date of Birth (MM/DD/YYYY) **Age** **Gender (M/F)**

Social Security Number **School** **Grade**

Address (Street, Apt.)

City, State, Zip

Home Phone Number **Cell**

Email

Emergency Contact **Relationship** **Home Tele No.** **Cell**

DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company Name **Telephone No.**

Insured's name **Date of Birth (MM/DD/YYYY)** **Relationship to Patient**

Insured's Social Security Number **I.D. Number** **Group No.**

Employer's Name _____

SECONDARY CARRIER

Insurance Company Name **Telephone No.**

Insured's name **Date of Birth (MM/DD/YYYY)** **Relationship to Patient**

Insured's Social Security Number **I.D. Number** **Group No.**

Employer's Name _____

MEDICAL INSURANCE

PRIMARY CARRIER

Insurance Company Name **Telephone No.**

Insured's name **Date of Birth (MM/DD/YYYY)** **Relationship to Patient**

Insured's Social Security Number **I.D. Number** **Group No.**

Employer's Name _____

SECONDARY CARRIER

Insurance Company Name **Telephone No.**

Insured's name **Date of Birth (MM/DD/YYYY)** **Relationship to Patient**

Insured's Social Security Number **I.D. Number** **Group No.**

Employer's Name _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Last Name **First** **MI**

Relationship to Patient **Social Security No.**

Address (Street, Apt.)

City, State, Zip

Home Phone Number **Cell**

Email

Occupation **Employer's Name** **Phone No**

Employer's Address (Street) **City** **State** **Zip**

SPOUSE

Last Name **First** **MI**

Relationship to Patient **Social Security No.**

Address (Street, Apt.) *if different from above

City, State, Zip *if different from above

Home Phone Number *if different from above **Cell**