Stephanie R. White D.M.D.
Gearhart Dentistry
3965 Hwy 101 N.
Gearhart OR 97138
(503)738-9273
frontdesk@gearhartdentistry.com

PATIENT INFORMATION

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

ACCOUNT INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

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PRIMARY INSURANCE

Patient Name: Last First MI Preferred Name

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

GETTING TO KNOW YOU

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY? Name, Phone Number

WOULD YOU LIKE TO HAVE A TEXT MESSAGE OR EMAIL SENT TO YOU TO CONFIRM YOUR NEXT FUTURE APPOINTMENT?

☐ Text Message ☐ Email ☐ Neither

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HIPPA - NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY. Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We keep a record of the health care services we provice you. You may ask to see and copy that record. You may also ask to correct that record. We will not diclose you record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting any of our staff members. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions to our Notice, at any time by contacting:
Telephone: 503-738-9273 Fax: 503-717-9323

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 the patient's dental need's.
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 medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I undersatnd 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.

MINOR PATIENTS: We ask that a parent or guardian must accompany anyone under 18 years of age. This person will be responsible for any payments.

ASSIGNMENT AND RELEASE:
Please sign below to acknowledge your understanding of the information contained herein. For individuals with insurance, your signature below additionally authorizes your insurance benefits to be paid directly to Stephanie R. White, D.M.D. It also authorizes the doctor to release any information required for payment and processing of your claims.

Patient/Responsible Party Name: Relationship to Minor Child:

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OFFICE POLICY & FINANCIAL PROTOCOL

Thank you for choosing Gearhart Dentistry as your dental health care provider. We want you to feel comfortable with our office regarding your financial and insurance matters, thereby preventing misunderstandings. We have found that once firm financial arrangements have been established, dental care can proceed in a timely, orderly fashion. Our office needs to know the method of payment you will be using to pay for your portion of dental treatment rendered to you and your family. Unless financial or insurance arrangements have been made in advance, payment for treatment rendered is expected in full at each visit. If you have dental insurance you will normally have a deductible and co-pay for all treatment. You should be prepared to pay these at every appointment.

PLEASE READ THE FOLLOWING OPTIONS CAREFULLY. Please list ALL family members that apply:

PAYMENT OPTIONS:
Please indicate how you plan to pay.

- ☐ Cash
- ☐ Credit Debit Card
- ☐ Check
- ☐ Flex Spending Account
- ☐ Care Credit

We accept MasterCard, Visa, Discover, American Express, in addition to specialty financing thru Card Credit. There will be $30.00 charge for all retuned checks.

If you plan on using a credit card please enter you card type and number:

Card Type: Number: Expiration Date: CVU:

We will bill your credit or debit card when we have received notification from your carrier that they have processed your claim and any balance remaining.

Please indicate if there is a limit you want charged to your credit/debit card.

- ☐ I desire to limit the amount billed to my credit/debit card to $100.00
- ☐ I do not wish to use a credit/card. If this option is chosen you will need to make financial arrangements prior to treatment starting. If prior arrangements are not made we will reschdule your appointment until treatment rendered can be paid in full

ACCOUNT BALANCES

We electronically file insurance the same day you're treated. The balance on all accounts is due in full in 90 days regardless of insurance coverage or anticipated payment from other sources. In the event that payment for our services is not made within 90 days of receipt of services, an interest charge of 2% per month (21% per annum) will be added to the account. Therefore, patients with insurance whose claims have not been paid within 60 days should contact their insurance carrier to determine the reason for delay of payment. Delinquent accounts will be referred for collection at the discretion of Gearhart Dentistry; a $50.00 charge will be assessed for all accounts sent to collections. If your account is turned over to a collection agency or attorney, you will be responsible for any collection fees and court costs.

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MINOR PATIENTS:
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MISSED APPOINTMENTS: Your dental health is our top priority. Please help us to better manage your health care by keeping your scheduled appointments. We require a 24-hour notice of any changes made for one-hour appointments and a 48-hour notice of any changes for extended appointments (90 minutes or longer). It is important we receive this notice otherwise a cancellation fee may be charged to your account.

A charge at the following graduated scale will be made for any missed appointment not cancelled within 24 hours of any appointment: 1/2 hour $50.00; 1 hour $100.00; each additional hour $50.00 per hour or fraction thereof. We are aware that at times there may be circumstances that will not allow the required notice.

At our discretion, we reserve the right to cancel your appointment if we are unable to confirm it. We must hear back from you 24 hours before or by 2:00 pm of the last business day before your appointment at the latest. Thursday is the last day of the week to cancel Monday appointments. Also, on occasion due to scheduling contingencies, we reserve the right to move your appointment up or down by up to 1/2 hour. In the event we have to make any appointment starting time changes we will notify you when we contact you to confirm your appointment.

PATIENTS WITH INSURANCE:

We believe that all patients deserve the best quality care. Regardless of the type of dental benefits you have, we treat all patients. We participate in some but not all PPOs and all indemnity insurance plans. We do not participate in HMO's or Oregon Health Plan. We do not take Medicaid. This does not mean we will not treat you. It simply means that you will have more out of pocket expenses.

Many insurance plans state that you will be covered up to "50%, 80%, or 100%." In spite of that statement, we have found that many plans may cover less than that depending upon their "usual and customary fees" and what services they choose to cover. Insurance companies use the term "usual and customary" when setting fee limitations on services. Please be aware that some insurance companies will pay a claim percentage based on their "usual and customary fees" not our actual charges. We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges and "usual and customary fees" other than to provide factual information as necessary.

Please keep in mind that the insurance contract is between the patient and the insurance company. Therefore, the patient is responsible for the total bill, regardless of insurance coverage determination. As a courtesy, we will submit all insurance for you. Your insurance company does not guarantee payment. You are responsible for the cost of all treatment rendered. If you desire to file your own insurance, please let us know. We will print the claim for you and you may submit it. You will receive payment directly.

Please indicate how you would like your insurance claim to be processed.

☐ I plan to submit my own insurance. If I choose to do this I will pay for any treatment rendered at each appointment.

☐ I assign submission and benefits to Gearhart Dentistry. Regardless of insurance payments, I understand I am responsible for the costs of all treatment rendered.

☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

Signature: _____ Date: _____

Response Date: _____