Responsible Party Account Setup

Multiple family set up with One Responsible Party will get One Billing Statement

******

Even if Children are the Policy Holder of their own insurance (like CHIP) they still need to be set up with a Responsibility Party

******

Changes to Account(s) may be made at any time, requests need to be made in writing, will require signature(s).

******

Responsible Party #1

PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: _____

*****Requirement for Responsible Parties: must be at least 21 Years Old and have a FULL TIME JOB and a BANK ACCOUNT and VISA IN YOUR NAME**

Copy of: Check all boxes that apply:

[ ] Patient [ ] Policy holder [ ] provided copy of DL [ ] No Dental INS

Name First, middle initial, Last (PERFERRED NAME) EMPLOYER

ADDRESS BEST PHONE# 2ND PHONE CONTACT # E-MAIL CONTACT

SSN UT DL # DOB MALE/FEMALE

PREFERRRED METHOD OF PAYMENT FOR SERVICES / CREDIT CARD INFORMATION TO KEEP ONFILE

Responsible Party #2

PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: _____

*****Requirement for Responsible Parties: must be at least 21 Years Old and have a FULL TIME JOB and a BANK ACCOUNT and VISA IN YOUR NAME**

Copy of: Check all boxes that apply:

[ ] Patient [ ] Policy holder [ ] provided copy of DL [ ] No Dental Ins

Name - First, middle initial, Last Perf. Name EMPLOYER

ADDRESS (same as above) BEST PHONE# 2ND PHONE CONTACT # E-MAIL CONTACT

SSN UT DL # DOB MALE/FEMALE

PREFERRRED METHOD OF PAYMENT FOR SERVICES / CREDIT CARD INFORMATION TO KEEP ONFILE

Policy Holder Setup

Policy Holder - PRIMARY

PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: _____

Copy of: Check all boxes that apply:

[ ] Patient [ ] Insurance Card [ ] Insurance Eligibility [ ] Ins Provider ONLY(not on acct)

Name (First, middle initial, Last) DENTAL INSURANCE COMPANY

YOUR PHONE # Policy Holders ADDRESS (REQUIRED FOR CLAIMS) DENTAL INS PHONE #

SSN (REQUIRED FOR ELIGIBILITY DOB EMPLOYEER POLICY ID #

Policy Holder - SECONDARY

PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: _____

Copy of: Check all boxes that apply:

[ ] Patient [ ] Insurance Card [ ] Insurance Eligibility [ ] Ins Provider ONLY (not on acct)

Name (First, middle initial, Last) DENTAL INSURANCE COMPANY

YOUR PHONE # Policy Holders ADDRESS (REQUIRED FOR CLAIMS) DENTAL INS PHONE #

SSN (REQUIRED FOR ELIGIBILITY) DOB EMPLOYEER POLICY ID #

*****We will keep information onfile, and will show you how to submit claims...but we are not set-up to submit or track claims on a 3rd policy.**

Policy Holder - THIRD

PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: _____

Copy of: Check all boxes that apply:

[ ] Patient [ ] Insurance Card [ ] Insurance Eligibility [ ] Ins Provider ONLY (not on acct)

Name (First, middle initial, Last) DENTAL INSURANCE COMPANY

YOUR PHONE # Policy Holders ADDRESS (REQUIRED FOR CLAIMS) DENTAL INS PHONE #

SSN (REQUIRED FOR ELIGIBILITY) DOB EMPLOYEER POLICY ID #

Dependents on the Account

PLEASE - Check box

[ ] Responsible Party(s) on account authorizes to pay for any and all treatment visits for the dependent child if he/she is sent to the dentist unaccompanied, or children that are "dropped off" for dental work.
Responsible(s) Party also agrees to pay for any and all treatment visits for the dependent child if he/she is sent to the dentist with a family member such as a Grandparent, Aunt, any other adult the parent sends the child with to the dentist with. Cobble Creek Dental, DDS will recognize the dependent child or the adult that accompanies the child authorized to sign treatment plans and schedule needed appointments.
We depend on the Responsible Party(s) to follow-up with our office, or the child following the appointment with any questions they may have about treatment received or charges on the account, or appointments scheduled.
We encourage Parents /guardians to accompany dependent children to the dentist and stay with them for the duration of the dental procedures, if possible.

Dependent on Account PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: ________

Relationship to Responsible Party ______________________________ Dependent is a Handicapped Adult: ______________

Name (First, middle initial, Last) (PREFERRED NAME)

ADDRESS (same as above – leave blank) BEST PHONE# 2^{ND} PHONE CONTACT # E-MAIL CONTACT

SSN UT DL # DOB MALE/FEMALE

Dependent on Account PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: ________

Relationship to Responsible Party ______________________________ Dependent is a Handicapped Adult: ______________

Name (First, middle initial, Last) (PREFERRED NAME)

ADDRESS (same as above – leave blank) BEST PHONE# 2^{ND} PHONE CONTACT # E-MAIL CONTACT

SSN UT DL # DOB MALE/FEMALE

Dependent on Account PLEASE PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS Acct ID: ________

Relationship to Responsible Party ______________________________ Dependent is a Handicapped Adult: ______________

Name (First, middle initial, Last) (PREFERRED NAME)

ADDRESS (same as above – leave blank) BEST PHONE# 2^{ND} PHONE CONTACT # E-MAIL CONTACT

SSN UT DL # DOB MALE/FEMALE

The information on this document for ACCOUNT SET UP for CCD was provided by:

_____

Please provide Name – PRINT FIRST NAME, MIDDLE INITIAL AND LAST NAME

Signature: _____October 3, 2013

I verify all information I have provided to be true and accurate to the best of my ability. I realize that providing correct information to the dental office in regard to my account and insurance is KEY to the successful of billing of my insurance for maximum payment on my account. I understand any and all balances not paid by insurance are due and payable by me. ***If I do not participate with Dental Insurance, I want to hear about options for zero interest payments, and discounts for dental work paid by cash, check or credit card on the day of service.***

OTHER IMPORTANT QUESTIONS FOR YOUR ACCOUNT:

WHO MAY WE THANK FOR THE REFERRAL OF YOU AND YOUR FAMILY? _____

WHO WOULD YOU LIKE US TO PUT DOWN FOR YOUR EMERGENCY CONTACT?

NAME: _____ _____

Please provide Name – PRINT FIRST NAME, Middle Initial, and LAST NAME

RELATIONSHIP: _____

PRIMARY PHONE NUMBER: _____

SECONDARY PHONE NUMBER: _____

PREFERRED PHARMACY FOR PERSCRIPTIONS: _____

Attention Patients – Do not write below this line – Office use only

Account set up by/Ins Set up: _____ (SCHEDULING COORDINATOR)

Registration Docs Approved by: _____ (SCHEDULING COORDINATOR)

Patient Photo/DL/INS Cards/Bank Acct Info Completed by: _____ (SCHEDULING COORDINATOR)

Doc's Scanned into Chart by: _____ (CCD EMP)

Verified by: _____ (OM or AOM)

Time 9:05 AM

Cobble Creek Dental, LLC

Date 9/24/2013

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes	
Do you use controlled substances?	○ Yes ○ No	If yes	

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

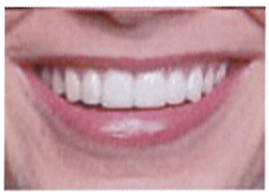
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

September 24, 2013

Beautiful**H**ealthy**S**miles**F**or**L**ife.



Please take a moment to tell us about you, and your smile.

What is your "PRIMARY DENTAL CONCERN TODAY"?

1. Do you currently have a dental condition or a tooth ache/pain that prompted you to schedule this appointment today? [ ]YES [ ] No

If you answered yes, where is the problem? _____

How long has this been going on? _____

Does the pain keep you up at night? _____

Have you taken any medicine for this problem, and if so what? _____

If possible, would you like this tooth treated today? _____

2. How long has it been since your last dental exam or last dental visit? _____Years/Months
3. How long has it been since your last panoramic x-ray (the big x-ray done every 3 years?)_____

Tell us about your "FRONT TEETH". If you could change anything about the teeth that show when you "SMILE" what would it be?

_____

1. Are you happy with the SHADE of your teeth? [ ]YES [ ]NO
2. Are you interested in our promotion for FREE LIFETIME WHITENING? [ ]YES [ ]NO
3. Do you like the way your front teeth are shaped? [ ]YES [ ]NO
4. Are your front teeth as straight as you would like them to be? [ ]YES [ ]NO
5. Are you interested in a FREE INVISALINE CONSULTATION? [ ]YES [ ]NO
6. Are you satisfied with their overall appearance? [ ]YES [ ]NO
7. Is there anything you'd like to change about your front teeth [ ]YES [ ]NO
8. Would you like a FREE CONSULTATION FOR A SMILE MAKEOVER? [ ]YES [ ]NO

Now tell us about your BACK TEETH – the ones you use to chew. If there was anything you could change about your back teeth, what would it be?

_____

******TURN OVER – MORE QUESTIONS ON BACK*****

1. Do you have any sensitivity to hot or cold or when you chew? [ ]YES [ ]NO
2. Do you have any difficulty chewing? [ ]YES [ ]NO
3. Are you missing any teeth? [ ]YES [ ]NO
4. Are you interested in a FREE IMPLANT CONSULTATION? [ ]YES [ ]NO
5. Does food get trapped and annoy you? [ ]YES [ ]NO
6. Is there anything in the back that you'd like us to look at? [ ]YES [ ]NO

Your GUMS aren't something most people think about, but let me ask you this:

1. Do your gums ever bleed? [ ]YES [ ]NO
2. Do you ever experience any sensitivity? [ ]YES [ ]NO
3. Do you worry about your breath, or feel you have bad breath? [ ]YES [ ]NO
4. Do you have gum recession? [ ]YES [ ]NO
5. Do you have any teeth that feel "a little loose" [ ]YES [ ]NO
6. Have you ever been gum disease or periodontal disease? [ ]YES [ ]NO

Denture and Partial Denture(s) Patients:

Mark Harris, DDS
KC Wilkins, DMD
And Founded By Douglas Cottle, DDS
(801) 399-0458

PATIENT CONSENT FORM

I authorize Dr. Mark Harris, DDS or Dr. KC Wilkins, DMD and/or such assistants/associates as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of my minor child or any other individual for which I have responsibility, including administration of any sedative (including nitrous oxide), analgesic, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

Signature_____ Date_____

COBBLE CREEK DENTAL

Office Policy and Insurance Authorization

FINANCIAL

Payments

Cash, check, Care Credit, major credit cards and insurance are accepted as payment in our office. Payments are expected at the time of service. Any payment plans or installments on service rendered MUST be approved of in writing and PRIOR to treatment.

Insurance

This office is happy to process your insurance claims promptly and at no charge. Insurance coverage is usually limited to a portion of the fee we charge. Your insurance contract **REQUIRES** your estimated co-payment at the time of service. If your estimated co-insurance payment is not paid on service date, you will not receive any insurance contract discounts. When you receive treatment in this office you agree to be financially responsible for the entire fee, the contract for your dental insurance is between **YOU** and **YOUR** Insurance Company. We gladly bill your insurance, but any problems or non- payment will be your responsibility to settle with your insurance company.

If you have *more than one insurance policy* we will gladly process your additional claims at no charge, however you will not receive any insurance contract discounts with multiple dental policies.

Discounts

A 10% cash courtesy discount is offered for services if paid in FULL with CASH or CHECK at the time of service. Patients with insurance must pay the TOTAL amount and wait for insurance to reimburse you. **Our office is required to notify your insurance of the discount, if a payment is to be made by your insurance.**

Statements

If your account has a balance, you will receive a statement. We charge a $5 statement fee.

MISSED APPOINTMENTS / LATE APPOINTMENTS

Missed appointments

Our office reserves specific time needed for each patient's treatment. We do a great deal of preparation that is costly and time consuming in order to provide each patient with the best quality care possible. Our office policy states that there will be a $25.00 fee for every 30 minutes for missed appointments when there is not a 23-hour notice given. This office may waive this fee under unusual circumstances.

Late appointments

If you are late for an appointment we will check with our clinical coordinator to see if there is still adequate quality time for the Dr. to do any of your treatment. Re-appointing may be necessary to perform all the proposed treatment in the proper reserved time.

EMERGENCIES

We strive to be available to handle our patients with emergencies. We keep specific time each day for that purpose. When you come in we will see what the problem is and what will need to be done. Generally, the Dr. will not have time to begin and finish work that arises from an emergency, but will attempt to get you out of pain and then appoint for the quality time necessary to finish treatment. Please call us as early as possible to ensure being able to see the Dr.

INTEREST AND COLLECTION FEES

All payments are due at the time of service. All accounts not paid within 30 days of service must make financial arrangements and will receive a 1.8% per month, 21.6 APR and late fees will be charged to all accounts where no payment is received of a minimum of $5.00 The undersigned specifically agrees to pay an additional amount representing thirty percent (30%) of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the costs associated with said collection action processing.

_____

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS POLICY Date

INSURANCE AUTHORIZATION

_____

I AUTHORIZE THE RELEASE OF ALL NECESSARY INFORMATION TO THE INSURANCE CARRIER AND THEIR REPRESENTATIVE; INCLUDING PAYMENT TO PROVIDER

_____

I understand that I am financially responsible for all fees as well as my portion at the time of service

COBBLE CREEK DENTAL

Financial Policy 2013

DENTAL INSURANCE -

Patient Portion is expected Day of Service; We accept the following forms of payment:

- Cash / Check
- MasterCard / Visa / American Express / Discover Card
- Health Savings Cards
- Care Credit (OAC) – the only "payment plan option"

INSURANCE ESTIMATING and POLICY-

When you check into our office for the first time, or provide us with new insurance information we contact your insurance company to confirm eligibility, and to get a breakdown of your coverage.
You are responsible to let us know if your insurance changes or terminates. Accurate information is key to claim submission.
We update our computer program with the information we receive from your insurance company; we want your treatment estimates to be accurate. We provide you with a detailed copy of your treatment plan, and ask for a signature to put into your chart. The original is given to you, the patient.
We are willing to bill both PRIMARY and SECONDARY Insurance for you. We submit all the claims and supporting documents to maximize coverage.
We no longer submit claims for a 3rd insurance policy for no charge. We will gladly provide you with all the information you need to bill a 3rd policy yourself. The fee to bill 3rd insurance is $22/claim or submission.
We will track and follow up on insurance claims for a maximum of 90 days from Date of Service. If your insurance has not remitted payment at that time, we will close the claim and you are responsible to pay in full.

NO DENTAL INSURANCE –

- Patient Portion is expected Day of Service; we accept the following forms of payment:
  - Cash / Check with a 10% discount.
  - MasterCard / Visa / American Express / Discover Card with a 5% discount
  - Health Savings Cards with a 5% discount
  - Care Credit (OAC) – the only "payment plan option"

STATEMENTS –

- NO CHARGE - date of service
- $5 – all other statements that we need to send in the mail asking for payment on the same treatment.

Signature of Responsible Party _____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____