Spring Dental

Patient's Name (First / Middle / Last) **Sex** M F

Birthday (Month / Day / Year) **Age** **Social Security #**

Home Address **City** **State** **Zip**

Cell Phone # **Home Phone #** **Email address**

Your Employer **Work Phone #**

Spouse's (if minor, Parent's) Name **Spouse (Parent) SS #** **Cell #**

Emergency Contact Name **Relationship** **Cell #**

DENTAL INSURANCE INFORMATION (Primary Insured Carrier)	
Insured's Name	
Insured's Employer	
Insurance Company	
Insured's Phone #	**DOB**
Insured's Social Sec. #	
Group #	**Member ID #**

FINANCIAL & HIPPA POLICY

Thank you for choosing Spring Dental as your dental healthcare provider! The Spring Dental family is passionate about your oral health. Below you will find our financial policy, which we require that you read, agree to, and sign before we begin any treatment.

Please note: returned checks will be subject to fees. In the event that we need to utilize a collection agency and/or legal assistance to collect, you will also be responsible for any of their charges.

If you have Insurance:

-For your convenience, we will provide an insurance estimate and we will help process your insurance claims. However, there is no guarantee that your insurance company will pay the full amount estimated.

-Your insurance policy is a contract with you, your employer, and your insurance company, and Spring Dental is not a party to that contract.

-Your insurance company will typically pay within 30-60 days from the time of claim submission. If they do not pay within 60 days, we will ask you to contact them to help expedite payment. If payment is not received, or your claim is denied for any reason at all, **you are ultimately responsible to pay the balance.**

-Spring Dental is committed to providing the best Dental treatment for our patients and our fees are customary for the industry and area. You are responsible for the agreed upon price, regardless of your insurance company's arbitrary determination of the reimbursement rates for the procedure(s)

-We require that you pay the co-payment and deductible. You can pay with cash, major credit card, or one of the third party financing options that we provide.

HIPAA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

Consent:

I have thoroughly read, reviewed, and understand and agree to the terms and conditions as listed above. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that ultimately payment for any Dental services rendered by Spring Dental to myself or any of my dependents is mine, and is due and payable at the time services are rendered, unless previous financial arrangements are made. I further understand that a finance, rebilling, attorney fee, and collection charge will be added to any overdue balance. By signing below, I authorize Spring Dental to call me at any number I provide, including calls or texts to mobile or similar devices for any lawful purposes.

Patient Signature (Parent if minor) **Date**