Financial, Insurance and Treatment Agreement

Welcome to **St. James Dentistry,** the office of **Dr. David Savage.** We know choosing a dentist can be a difficult decision so we are grateful to care for your dental health. Our goal is to provide quality dental care in a comfortable, friendly and relaxing atmosphere. We utilize the latest technologies for diagnosing and treating your individual dental conditions in order to recommend the best treatment options tailored for you.

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 will be billed any additional amount. You will receive an **estimate** of your fees 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 time of service. We may require a deposit at the time of appointment for services that require use of a dental laboratory outside from our office. Our office will let you know of any required deposit in advance. We will file insurance claims for you, 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. Other payment options are available upon request from our financial coordinator.
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 90 days. In the event that clinical conditions warrant a different treatment, or a change in fees, you will be notified of changes prior to the procedure.
8. In the event of default of payment after 90 days, accounts in which effort to pay is not made will be subject to collection proceedings.
9. We do not charge fees for broken appointments because we understand emergencies do arise, but in fairness to our other patients' dismissal from the practice will be considered following three canceled appointments without 24 hour notice.

Again, thank you for choosing our office for your dental care and if there is anything we can do to make your visit more pleasant, please let us know. We value building long term relationships for years to come with you and your family.

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_____

TIME 9:11 AM DATE 8/28/2017

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

MEDICAL HISTORY FORM 2014

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, c

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
Have you ever taken Fosamax, Boniva, Actonel or a medication containing bisphosphonates?	○Yes ○No	If yes
Are you on a special diet?	○Yes ○No	
Do you use tobacco?	○Yes ○No	
Do you have an Artificial Joint? Are you required to premedicate with antibiotic?	○Yes ○No	If yes
Do you currently take Coumadin/Warfarin?	○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 Allergies?	☐	If yes
Do you use controlled substances?	○Yes ○No	If yes

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

☐ High Blood Pressure	☐ Pacemaker/Defibrillator	☐ Cancer	☐ Hemophilia
☐ Stroke	☐ Artificial Heart Valve	☐ Lung Disease	☐ Diabetes
☐ Heart Attack/Failure	☐ Anaphylaxis	☐ Emphysema	☐ Cortisone Medication
☐ Heart Murmur	☐ Epilepsy/Seziures	☐ Asthma	☐ Thyroid Disease
☐ Congenital Heart Disorder	☐ Renal Dialysis	☐ AIDS/HIV	☐ Cold Sores/Fever Blisters
☐ Mitral Valve Prolapse	☐ Tuberculosis	☐ Hepatitis B or C	☐ Osteoporosis

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

Comments:

Dental History

Do your gums bleed when you brush or floss?	○Yes ○No
Have you ever had orthodontic (braces) treatment?	○Yes ○No
Do you grind or clench your teeth?	○Yes ○No
Are you interested in cosmetic dentistry options?	○Yes ○No
Are you interested in Whitening Treatments?	○Yes ○No

How long has it been since your last dental visit?

St. James Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:
Purpose of this Consent: By signing the 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 sign this consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, healthcare operations, of the use and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice of Privacy Practices is available at the front desk. We encourage you to read over it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in the Notice of Privacy Practices. If we change our privacy practice, 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 we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of your notice, at any time, by contacting:

St. James Dentistry
3416 Holmestown Road
Myrtle Beach, South Carolina 29588

Signature

I,_____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature of Patient or Representative:_____

Date:_____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name:

Relationship to Patient:

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation, submitted to the contact person listed above. Please understand that the revocation of this consent will NOT affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue to treat you if you revoke this consent.