

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

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

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

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

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

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

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

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

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

John P. Nairn, D.M.D.
Gregory A. Nairn, D.M.D.

131 S. College Street
Washington, PA 15301

Phone: 724-228-3142

Fax: 724-228-9771

Associates in Dentistry Office Policies

1. We require at least 24 hours advance notice for appointment cancellations.
2. If your notice of office cancellation is not received within the specified time, and the appointment is not kept, this will constitute in a broken appointment. We reserve the right to charge a \$50.00 fee before another appointment can be scheduled.
3. We reserve the right to reschedule an appointment for patients arriving more than (15) fifteen minutes late. Further, due to time constraints, we reserve the right to perform only those procedures that will fit the doctors schedule.
4. We reserve the right to terminate dental treatment/services for any patient that has more than three broken appointments.
5. We reserve the right to reschedule an appointment, or to perform only one dental procedure for patients arriving more than (15) fifteen minutes late.
6. There will be a \$25.00 fee for all returned checks.
7. All dental procedures not covered by your insurance (private insurance or all state Medicaid plans) will have to be paid by the responsible party. Please review your dental benefits booklet carefully as each insurance company may have different coverage schedules.
8. Unmet dental insurance deductibles and uncovered procedures must be paid the day the services are rendered.
9. Any patient that does not have dental insurance (cash paying patient) must pay balances in full the day the services are rendered.
10. Insurance co-payments are to be paid prior to procedure completion and before scheduling the next appointment.

Authorization and Release

My signature below acknowledges that I understand the office policies at Associates in Dentistry. I further understand that my child's dental treatment is conditioned on the above policies. It is further understood that "we" refers to Associates in Dentistry.

Signature of Patient: _____ Date: _____

John P. Nairn, D.M.D.
Gregory A. Nairn, D.M.D.
131 S. College Street
Washington, PA 15301
Phone: 724-228-3142
Fax: 724-228-9771

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

▶ Although we are willing to complete and submit insurance claim forms on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand this does not eliminate your financial responsibility for your treatment.

▶ We require you to sign this form and/or any other necessary documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

▶ **We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.**

▶ Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We provide routine insurance billing procedures upon verification of eligibility. Our office does not automatically send PreAuthorizations to your insurance company. You may request that we do. If your claim is denied, you will be responsible for paying the full procedure amount.

▶ Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office in the 60 days, we will ask you to pay the balance due at that time. You may then have to seek reimbursement from your insurance company.

▶ Our office **will not** enter into a dispute with your insurance company over any claim. We will provide any necessary documentation and radiographs your insurance company requests to process a claim. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Print Name

Signature of Patient/Responsible Party

Date

John P. Nairn, D.M.D.
Gregory A. Nairn, D.M.D.

Associates in Dentistry Dental Insurance Review

Dear Valued Patient,

Associates in Dentistry has prepared this memorandum to help you better understand the complexities of dental insurance. We realize how confusing it can be.

1. We would like to highlight a misconception – dental insurance is not designed to pay for all dental care. It is basically a supplement to medical insurance, much like vision coverage. Most dental insurances have limits and/or various degrees of co-payments and deductibles.
2. The payments made to Associates in Dentistry by dental insurance companies are based on usual, customary, and reasonable (UCR) fees. This means that the insurance companies determine a list of covered dental services with an assigned dollar amount. That dollar amount represents just how much the plan will pay for those services that are covered. Every insurance company has different UCR tables and most have several different tables. This can also include annual deductibles and maximums, exclusions, and limitations.
3. Most often, the UCR table does not represent the dentist's full charge for those services. If it is noted that the fee that your dentist has charged you is higher than the reimbursement levels of UCR, this does NOT mean your dentist is overcharging you. Although these limits are called "customary," they may or may not accurately reflect the fees that dentists in Southwestern PA charge. There is a wide fluctuation and lack of government regulation on how a plan determines the "customary" fee level.
4. Our fees are based on a combination of our costs, our time, and our constant dedication to providing our patients with the highest quality dental care.
5. The treatment recommended by our office is never based on what your insurance company will pay, but on what is needed to maintain healthy oral hygiene.
6. It should be understood that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility.
7. We will do our best, based on the information you provide us, to predict what your level of coverage for a particular procedure will be. However, it is up to the patient to verify specific dental benefits or coverage. The patient is responsible for payment of the difference.

Signature of Patient: _____ Date: _____

John P. Nairn, D.M.D.
Gregory A. Nairn, D.M.D.
131 S. College Street
Washington, PA 15301

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, HAVE RECEIVED OR READ A COPY OF THIS
OFFICE'S NOTICE OF PRIVACY PRACTICES.

PRINT NAME

SIGNATURE

DATE

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, HOWEVER
ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

___ INDIVIDUAL REFUSED TO SIGN

___ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

___ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

___ OTHER: PLEASE SPECIFY

