CALEDONIA
FAMILY DENTISTRY

Date: _____

Previous Dentist Information

Name: _____

Address: _____

_____

_____

Please send a copy of the most recent radiographs and records to our office.

Thank you for your timely response.

EMAIL: staff@caledoniafamilydentistry.com

Address: 3352 Brown Rd. Caledonia, NY 14423

Phone: 585-538-4500 Fax: 585-538-9565

Patient Name: _____ Date of Birth: _____

Address: _____

_____

_____

Parent/Guardian Signature: _____ Date:_____

Thank you,

Caledonia Family Dentistry

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I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers (dental insurance)
- Conduct normal healthcare operations such as send appointment reminders, make reminder phone calls and scheduling appointments

I acknowledge that I have the right to receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

(Please Print)

Relationship to patient (if minor): _____

Signature: _____

Date: _____

If you would like other family members to have access to your dental information, please include their names below:

_____ (Relationship to Patient): _____

_____ (Relationship to Patient): _____

_____ (Relationship to Patient): _____

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FAMILY DENTISTRY

Financial Policy

We are honored that you have chosen Caledonia Family Dentistry for your dental care. The following is our financial policy:

Payment for dental treatment is due at the time of service. Cash, Check, Visa, MasterCard and Discover are accepted forms of payment.

If the patient has dental insurance coverage, the procedure claim will be sent to the patient's insurance company first. If there is a balance after insurance payment, the patient will then be responsible for the balance and subsequently billed accordingly.

If the procedure has been pre-authorized to your insurance company and the balance is known (i.e. crowns, dentures, implant restorations, etc.) then the balance is due at the time of completion/insertion. Please be advised that for crowns done in one visit, this balance would then be due that day.

For procedures requiring multiple appointments (this would include implant restorations, dentures, partial dentures, etc.) half of the balance is due at the time of impression, when the case is to be sent to the lab. The remaining half is due at the time of insertion/completion.

It is your responsibility to know whether or not you have dental insurance coverage or not. It is also your responsibility to understand what may or may not be covered by your plan and at what percent coverage. Our staff is not responsible for understanding your insurance policy, its coverage and/or limitations. We would be happy to assist, however any questions regarding your specific coverage should be directed to your insurance company directly.

Returned checks will incur a $40 chargeback fee.

All balances not paid within 45 days will incur a $10 service fee for every month the balance is not paid upon. For patients with insurance coverage, this 45 day time-frame will begin from the date your insurance has paid and the patient's balance is known. The undersigned also agrees to pay all reasonable attorney's fees and collections costs in the event that any unpaid charges and fees are referred to an attorney or collection agency.

Lastly, we understand that each patient has different financial situations and limitations. For balances that exceed $500, we would be happy to work with you and determine a payment arrangement that you are comfortable with. However, please understand that if you are unable to pay for your treatment in full at the time of service that a financial arrangement needs to be set up in ***advance*** of the procedure being billed.

By signing this financial policy you are stating that you have read and agree to the terms stated within. Thank you for choosing Caledonia Family Dentistry.

Signature: _____ Date: _____

Print Name: _____