ANKENY DENTAL ASSOCIATES PC

Name: _____ / / M / F
Last First Middle Date of Birth Sex

Mailing address: _____
City State Zip

Home Phone: ( ) Cell Phone: ( ) Occupation: _____

Email: _____ SS# _____

Emergency Contact: _____ ( ) ( )
Relationship: Home Phone Cell Phone

If patient is a minor: _____
Parent/guardian name Relation

How do you prefer to be contacted: ☐ Phone ☐ Text ☐ Email

Patient Treatment Consent/Agreement

Please Read Written Agreement on back of form before signing

The undersigned authorizes Ankeny Dental Associates to submit claims (on the patient's behalf) to insurance, Medicare, Medicaid, or other third party payer(s) and to disclose health information to the extent necessary to obtain payment. The undersigned also assigns benefits paid by insurance, Medicare, Medicaid, or other third party payer(s) directly to Ankeny Dental Associates. In consideration of the dental services provided, the undersigned assigns to Ankeny Dental Associates any benefits to which the undersigned may be entitled to receive, including without limitation any such benefits due or claims the undersigned has under or pursuant to a benefit plan governed under ERISA, 29 USC sec. 101 et seq.

I have reviewed Ankeny Dental Associates' Financial Policy as listed on the back of this form and I understand and accept responsibility of cooperating with these policies. I understand that I will be responsible for financial balances resulting from treatment received that is not paid by my insurance company, Medicare, Medicaid, or any third party agency.

My signature acknowledges that I understand and accept the above agreement.

_____ _____ _____
Signature Print Name Date

Acknowledgement of Receipt of Notice of Privacy

You May Refuse to Sign This Acknowledgment

I acknowledge that I have received a copy of this office's **HIPAA Notice of Privacy Practices.**

_____ _____ _____
Signature Print Name Date

Updated 1/1/2016

Consent to Treatment

The signee consents to radiographs (x-rays), laboratory procedures, anesthesia, diagnostic tests, dental treatment, or other procedures rendered to the patient under dentist supervision. Although the signee may elect not to undergo certain specific procedures, without adequate diagnosis or treatment plan Ankeny Dental Associates' may decline to treat the patient.

Privacy Practices

The signee has received Ankeny Dental Associates' Notice of Privacy Practices and consents to the use and disclosure of their health information to carry out treatment, payment activities, and health care operations. The signee has the right to revoke consent at any time by written notice. However, we may decline to treat the patient if this consent is revoked.

Financial Agreement

The signee agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Ankeny Dental Associates' in accordance with the regular rates as deemed by the fee schedule. Should the account be referred for collection, the signee shall pay reasonable attorney's fees and collection expenses. If a patient's account is sent to collections, Ankeny Dental Associates' will provide only emergency treatment for pain and swelling until the account is current. Failure to pay for services in a timely manner may jeopardize a patient's access to routine dental care.

Minors and Dependent Adults

- All patients under the age of 18 or dependent adults must register the name, address, and social security number of the adult responsible for payment.
- Either parent or legal guardian may be held responsible for payment of treatment rendered to their minor child or dependent adult.
- In the event of a divorce or separation, both parents may be held responsible for payment of treatment rendered to their minor child.

Payment

- Full payment is due on the day service is provided.
- Cash, check, Care Credit, or credit card (Visa, MasterCard, and Discover) are accepted for payment.
- Returned checks due to insufficient funds will incur a $25 fee.

Insurance

- All insurance information must be registered at the initial appointment and updated when information changes.
- Patients must provide a copy of his or her dental insurance card.
- Prior approval can be submitted after presentation of a treatment plan. This is not a guarantee of payment. Patients must initiate the request.
- Patients who have dental insurance will pay their estimated portion at time of service. Once insurance payment is received, the patient will be billed/refunded any difference to their account.

Cancellations and Broken Appointments

- If you are unable to keep your scheduled appointment we respectfully request a **24 hour cancellation notice.**
- If notice is not given prior to 24 hours a **$35 charge** will be applied to your account.