Advanced Periodontics & IMPLANTOLOGY

Patient Financial Policies

In an effort to help you understand, and to meet your financial obligations to our practice, we have put together the following policies. We understand that sometimes it may be difficult to meet your financial obligations. If this should occur, we encourage you to discuss your account and any payment arrangements with our Office Manager.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I authorize Advanced Periodontics & Implantology to furnish my insurance company with all necessary information regarding my present condition. I also authorize payment of dental benefits to Advanced Periodontics & Implantology.

Please initial each policy, then sign, and date:

____**Insurance.** Contact your insurance carrier and/or representative prior to your appointment regarding your plan coverage. Patients are responsible for knowing their individual plan benefits and if we are a participating provider with your insurance plan. As a courtesy to you, this office will file claims for all visits and procedures. *This is not a guarantee of coverage. We will only re-bill your insurance once.* ***You are responsible for payment of all co-pays, deductibles, co-insurance, and non-covered services. If your insurance does not pay after 60, days the account balance will be your responsibility.***

____**Non-Covered Services.** Your dental insurance company may determine that your visit/surgery/procedure with our doctor is not a "dental necessity," and will deny payment for our services. If this happens, it is your responsibility to pay for these services.

____**No Insurance.** Patients who do not have insurance are expected to pay for all services the day of their appointment before services are rendered.

____**Returned Checks.** Your account will be charged a $30.00 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and fees.

____**Past Due Accounts.** All services provided are payable within 30 days. Patients, who fail to make payment arrangements or have not expressed interest in meeting their financial obligations will be turned over to our collection agency. Collection and Late Fee Charges will be added to your account. You are **ineligible** to be seen in our office until you satisfy your financial obligations. Future services must be paid for in advance before you are seen by our doctor.

____**Collections.** We take pride in services we provide and appreciate your prompt payment. If your account has a balance for over 30 days, your account will be reviewed. At this time you may be charged a late fee, and the process of sending the account to an outside collection agency may begin.

____**Surgeries.** When a surgical procedure is scheduled, we will give you an estimate of the amount you will be responsible to pay. The amount is collected before the procedure(s) is/are performed.

____**Rescheduling.** At our practice we pride ourselves in seeing our patients in a timely manner and reserve the doctor's time for each patient. To offer this service to our patients we require 48 business hours notice if you need to change an appointment. If an appointment is canceled with less than 48 business hours you will assess a fee of $100 per hour of doctor's time and $50 of hygienists time and we will require a deposit to reserve the appointment for you again.

____**Cell Phone**. I consent to the dental practice using my cell phone number to call and text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) (_____)_____-_____ _____(**initial**)

I have been informed of **Advanced Periodontics & Implantology's Patient Financial Policies.** By signing I have read and understand that I am responsible for all charges incurred by me regardless of Insurance Coverage.

Patient's Name (Printed Name)_____ Date_____

_____

Patient / Legal Guardian (*Signature)* Relationship

Advanced Periodontics & IMPLANTOLOGY

Date:_____

Name: First _____ Last _____ Middle _____ Age_____

Birthdate:_____ Social Security or Drivers License #_____ □S □ M □ D □ W □ Minor*

Address: _____ Zip:_____

Phone: Home _____ Cell _____ Work _____

Email address: _____ Best number to reach you: _____

Name of Employer: _____ Occupation: _____

Family Dentist: _____ Other family members seen by us:_____

Emergency Contact Person:_____ Relation:_____Phone:_____

Preferred Pharmacy and it's location: _____

*If a Minor who is responsible guardian? Name:_____ DOB:_____ SS:_____

Address:_____ Zip:_____

Private Pay Information
Payment is due and payable in full at time of service.

For your convenience, we offer the following methods of payment. Please select the option you prefer:
□ Cash □ Personal Check □ Credit Card

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insureds Birthdate: _____ Insureds Social Security #: _____

Insurance Company: _____ Insureds Employer:_____

Secondary Insurance

Name of Insured: _____ Relationship to patient: _____

Insureds Birthdate: _____ Insureds Social Security #: _____

Insurance Company: _____ Insureds Employer:_____

Patient Medical History

How is your general health? □ Good □ Fair □ Poor *B.P. Today:*_____

Are you under the care of a physician? □ Yes □ No For what? _____

Primary Care Physician Name: _____ Phone: _____

Cardiologist Name: _____ Phone: _____

Have you been hospitalized in the last 2 years? □ Yes □ No

If yes, please specify: _____

Do you require antibiotic pre-medication prior to a dental procedure? □ Yes □ No

Are you **allergic** to any of the following? Please mark Yes or No:

Yes	No		Yes	No		Yes	No	
□	□	Aspirin	□	□	NSAIDs/Ibuprofen	□	□	Sulfa Drugs
□	□	Benzodiazepines/Sedatives	□	□	Tetracycline	□	□	Jewelry
□	□	Codeine or Hydrocodone	□	□	Clindamycin	□	□	Latex
□	□	Dental Anesthetic	□	□	Penicillin/Amoxicillin	□	□	Other:_____

Do you or have you ever smoked or used tobacco in any form? □ Yes □ No If yes, how often?_____

Are you taking Aspirin, NSAIDs, Fish Oil, Warfarin, Coumadin or any other blood thinners? □ Yes □ No

Do you have or have you had any of the following? Please mark Yes or No:

Yes	No		Yes	No		Yes	No	
□	□	Abnormal Bleeding	□	□	Fainting/Dizziness	□	□	Kidney Problems
□	□	Alcohol/Drug Abuse	□	□	Seizure/Epilepsy	□	□	Osteoporosis/Osteopenia
□	□	Blood Disorders	□	□	GERD/Acid Reflux			Last T-Score:_____
□	□	Bruise Easily	□	□	Stomach/Intestinal Problems	□	□	Glaucoma
□	□	Artificial Joints	□	□	Artificial heart valves	□	□	Liver Disease/Jaundice
□	□	TMJ/TMD	□	□	Atrial Fibrillation	□	□	Hepatitis
□	□	Tonsilitis	□	□	Breathing Problems	□	□	Thyroid Problems
□	□	Bacterial/Infective Endocarditis	□	□	Congenital Heart Disease/MVP	□	□	High Blood Pressure
□	□	Sleep Apnea/CPAP	□	□	Pacemaker	□	□	Lung Disorders/Asthma
□	□	Depression/Bi-Polar/SSRIs	□	□	Heart Attack/Angina			Tuberculosis/Emphysema
		Psychiatric Problems/MOAIs	□	□	Heart Surgery	□	□	Stroke
□	□	Dry Mouth or Mouth Breathing	□	□	Cancer, or family history of	□	□	Sinus Problems
□	□	Diabetes Type I/II	□	□	Radiation Treatment	□	□	Restless leg syndrome
		Last HbA1c:_____	□	□	Immune Disorder			
					(Lupus, HIV, AIDS)			

Reviewed By: _____

Have you ever taken any of the following cancer or bone enhancing drugs? □ Yes □ No
Bevacizumab (Avastin), Sunitinib (Sutent), Denosumab (Prolia), Denosumab (Xegeva), Zoledronic acid (Zometa), Palmidronate (Aredia), Zoledronic acid (Reclast), Ibandronate (Boniva), Alendronate (Fosamax), Risedronate (Actonel), Etidronate (Didronel), Tiludronate (Skelid), Clodronate (Bonefas)

Are you able to climb 1-2 flights of stairs without being tired? □ Yes □ No

Do you currently have a respiratory illness? □ Yes □ No

Have you had a cough for at least 3 weeks? □ Yes □ No

If yes:

Have you had coughing fits that interfere with eating, drinking, or breathing? □ Yes □ No

Are you having any symptoms in addition to your cough? □ Yes □ No

Have you been exposed to anyone with an infectious aerosol transmissible illness? □ Yes □ No

List any medications you are taking, including over the counter medications or supplements:

_____

_____

_____

Have you had any disease, condition, or problem not listed? □ Yes □ No If yes, please explain:

_____

_____

For Women Only: Are you taking birth control medication? □ Yes □ No Are you nursing? □ Yes □ No

Are you Pregnant? □ Yes, trimester:____ □ No □ Not sure

Patient Dental History

Present dental complaint/what is your goal for today's visit? Please explain: _____

_____

_____

Are you having discomfort at this time? □ Yes □ No

If yes, please explain: _____

Have you had periodontal treatment in the past? □ Yes, _____ □ No

Have you had orthodontic treatment (braces)? □ Yes □ No Do you wear/have a retainer? □ Yes □ No

Are you aware of grinding your teeth? □ Yes □ No Clenching your teeth? □ Yes □ No

Do you wear a mouth guard? □ Yes □ No Do you have TMJ/Jaw Joint problems? □ Yes □ No

When was your last professional cleaning? _____ How often?_____

How often do you brush your teeth? _____How often do you floss your teeth? _____

Is your toothbrush: □ Electric □ Hand brush □ Soft □ Medium □ Hard

Are your teeth sensitive? □ Yes, sensitive to_____ □ No

Have you had trouble with previous dental treatment? □ Yes □ No

If Yes, please explain:_____

Does dental treatment make you nervous? □ Yes □ No

Are you interested in sedation during your dental treatment? □ Yes □ No

Medicare Opt-Out Private Contract
for Patients who are eligible or have Medicare

This contract between Dr. Beatrice Criveanu, DDS, MSD ("Dentist") and_____(name) (Medicare beneficiary, referred to in this contract as "Patient") allows Dentist to provide treatment to Patient without being subject to Medicare limits. To do so, the law requires Dentist to "opt out" of Medicare and that no Medicare claim be filed for the treatment of Patient by Dentist.

Dentist represents that Dentist is excluded from participation under the Medicare program under section 1128,1l 56 or 1892 of the Social Security Act; in addition, Patient and Dentist agree that Patient is not now facing an emergency or urgent health care situation.

By signing this contract, Patient does the following:

(i) agrees not to submit a Medicare claim (or to request that Dentist submit a claim) for services or items supplied by Dentist, even if they are otherwise covered under Medicare;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentist, and understands that no reimbursement will be provided under Medicare for those services or items: in particular, Patient will pay for such services at Dentist's usual rate, in accordance with Dentist's payment policies;

(iii) acknowledges that Medicare limits do not apply to amounts that Dentist may charge for such services or items;

(iv) acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare: and

(v) acknowledges that Patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Medicare. (Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other dentists who have not opted out.)

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Dentist's current opt-out period. The expected expiration date of Dentist's opt-out period is January 4, 2019.

Accepted and Agreed: Beatrice Criveanu DDS Inc
Dentist

Patient’s Name:_____ Date:_____

Accepted and Agreed:_____
Signature of Patient or Patient's Legal Rep

Advanced Periodontics & IMPLANTOLOGY

General Consent

1. I hereby authorize the Doctor and the hygienist to perform the necessary services or surgical procedures for the treatment and/or prevention of periodontal disease and to do whatever procedures that their judgment may dictate during treatment.
2. I also authorize the administration of medications, such as anesthetics and analgesics, as may be deemed advisable by the Doctor, hygienist, or by the anesthesiologist selected to administer medications.
3. I understand that the proposed treatment, like all treatments, has some risks. I have been informed by the periodontist and understand the risks associated with either the pursuance or non-pursuance of periodontal therapy as well as the benefits that may be realized.
4. I certify that I have read and understand the above information to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Doctor to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such dental care to third party payers/or health practitioners.
5. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Patient Signature:_____ Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of the Advanced Periodontics & Implantology of Privacy Practices.

_____[Please Print Name]

_____[Signature]

_____[Date]

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

Personal Representative's name

Relationship to Patient _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)