Patient Financial Policies

In an effort to help you understand, and to meet your financial obligations to our practice, we have the following policies in place. 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 prior to your account becoming delinquent.

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 directly 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 your 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 within 5 business days of notification.

____**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 a collection agency. Collection fee ($25) and Late Fee Charges ($5) will be added to your account per month. 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 the 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 will be charged a late fee, and the process of sending the account to an outside collection agency will begin. If your account is sent to a collection agency you will be charged a collection fee.

____**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.** My signature indicates that 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

Date:__________________

Name: First _____________________ Last ______________________ Middle __________ Age_______

Birthdate:__________ Social Security #__________ Drivers License #_________ □S □ M □ D □ W □ Minor

Address: ____City:_________________ Zip:________

Phone: Home ________________ Cell ______________________ Work _______________________

Is it okay to leave personal/medical information on a voice mail? □ Yes □ No

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

Primary Dental Insurance Information

Name of Insured: __________________________________ Relationship to patient: ________________

Insureds Birthdate: _________________________ Insureds Social Security #: _____________________

Insurance Company: _____________ Insurance Phone#___________Insureds Employer: ____________

Secondary Dental Insurance Information

Name of Insured: __________________________________ Relationship to patient: ________________

Insureds Birthdate: _________________________ Insureds Social Security #: _____________________

Insurance Company: _____________ Insurance Phone#___________Insureds Employer: ____________

Patient Medical History

How is your general health? □ Good □ Fair □ Poor

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

Primary Care Physician Name: __________________________ Phone: __________________________

Specialist (Cardiologist, oncologist, nephrologist, etc.): ___________________________ 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 Reason:_______________ □ No

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

Yes No
□ □ Aspirin
□ □ Benzodiazepines/Sedatives
□ □ Codeine or Hydrocodone
□ □ Dental Anesthetic

Yes No
□ □ NSAIDs/Ibuprofen
□ □ Tylenol
□ □ Clindamycin
□ □ Penicillin/Amoxicillin

Yes No
□ □ Latex
□ □ Jewelry
□ □ Other:____________________
□ □ Other:____________________

Do you currently, or have you ever, smoked or used tobacco in any form? □ Yes □ No

Do you currently, or have you ever, smoked or used marijuana in any form? □ Yes □ No

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

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

Yes No
□ □ Depression/Bi-Polar/ Psychiatric Problems
□ □ Drug/Alcohol abuse
□ □ Glaucoma
□ □ Abnormal Bleeding
□ □ Bruise Easily
□ □ Blood Disorders
□ □ Hepatitis A/B/C
□ □ Breathing Problems
□ □ Sleep Apnea/CPAP
□ □ Sinus Problems
□ □ Dry Mouth or Mouth Breathing
□ □ Respiratory illness
□ □ Cough for >3 weeks
□ □ Vaping

Yes No
□ □ Osteoporosis/Osteopenia
□ □ Immune Disorder (Lupus, HIV, Sjogrens)
□ □ Fainting/Dizziness
□ □ Seizure/Epilepsy
□ □ Stomach problems/ Ulcer
□ □ GERD/Acid Reflux
□ □ Kidney Problems/Dialysis
□ □ Thyroid Problems
□ □ Cancer, or family history of
□ □ Radiation Treatment
□ □ Liver Disease
□ □ Diabetes Type I/II
Last HbA1c:______
□ □ Restless leg syndrome

Yes No
□ □ Artificial heart valves
□ □ Infective endocarditis
□ □ Congenital Heart Disease
□ □ Heart Attack/Angina
□ □ Heart Surgery
□ □ Pacemaker
□ □ High Blood Pressure
□ □ Stroke
□ □ Pregnant
Trimester 1/2/3
□ □ Nursing
□ □ Birth control medication
□ □ Lung Disorders/Asthma
□ □ Tuberculosis/Emphysema

Reviewed By: __________

Have you ever, or currently taking, 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)

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

____

____

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

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

Medication	Reason	Medication	Reason

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 (gum/jaw bone) 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

Do you use Fluoridated dental products? □ Yes □ No

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

If you are a candidate, are you interested in sedation during your dental treatment? □ Yes □ No

My signature below indicates that I have answered all questions truthfully and have not withheld any information. Signature:____________________ Date:_____________

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

This contract between Dr. Beatrice Criveanu, DDS, MSD and associates ("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 1128,1I 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.

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, associates, 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)