FINANCIAL AGREEMENT

This agreement is to inform our patients of our Financial Policy at Williams Dental of Cincinnati.

DENTAL INSURANCE

· Knowledge of covered benefits as well as amounts limitations exclusions waiting periods etcetera are exclusively the *patient's responsibility.*

· Our office will provide all necessary documentation supportive of recommended treatment plans in order to prove rationale and reasons for medical necessary.

· Completing insurance forms for our patients is a courtesy offer to help facilitate timely payments from insurance companies. This process does not eliminate the patient's financial obligation. We are happy to help submit dental claims on behalf of our patients, but we do not accept responsibility for the outcome of the transaction.

· Assignment of benefits from insurance companies are accepted by our office but the terms of agreements regarding dental benefits are between the insured (beneficiary), the employer, and the insurer (insurance company). Although we may estimate insurance benefits, we are *NOT* responsible for their accuracy.

· Not all dental services provided in our office represent covered benefits under an individual plan therefore payment for treatment cannot be guaranteed. If a claim is denied, full payment becomes the *patient's responsibility* at the time of services are rendered, accepting our service indicates the patient's acceptance of such responsibility.

· Our practice will not enter into a dispute with any insurance company over claims. Once complete documentation is submitted to the insurance carrier it is the responsibility of the insured to resolve any type of dispute over payments to be rendered to our office.

· Insurance payments are typically received within 30 to 60 business days from the time of billing. All charges not paid by the insurance company **within 90 days from the date of billed procedure** become the *patient's responsibility* regardless of the reason for non-payment.

PAYMENT FOR TREATMENT RENDERED

· All charges incurred for any treatment provided in our offices are the patient's responsibility regardless of insurance coverage.

· The copayment is the portion of the cost of the treatment not honored by the dental insurance.

· Timely payment of financial responsibilities helps maintain administrative costs and dental fees low.

· As we work with our patients to deliver optimal oral and dental health, we require the estimated copayment for treatment be paid at the time of service.

· Our practice accepts cash, personal check, MasterCard, visa, discover and American Express.

· The estimated Copayment may be adjusted after completion of treatment depending upon the final reconciliation of insurance payments.

PAYMENT PLANS

· We understand temporary financial problems which may affect timely payment of balance in those situations we encourage you to immediately communicate any such problems so we may discuss available alternatives and manage your account.

· We are pleased to offer care credit a financial company which helps devise individual payment plans that allows completion of dental work without delay and helps fulfill financial responsibility in monthly installments. Applications may be submitted in the office or online at www.carecredit.com. Approval may be obtained within 10 minutes.

OVERDUE BALANCE

· Accounts with unpaid balance passed 90 days are submitted to a collection agency.

· Costs incurred in debt collections include: additional interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with debt collection.

· Above referenced expenses are the *responsibility of the patient*.

DENTAL RECORDS

· A copy of dental records or radiographs will be provided *upon written reques*t, for a nominal fee.

CANCELLATIONS AND RESCHEDULING DENTAL VISITS

· Prior notice of *24 business hours* (weekends are not considered business hours) is required to cancel and reschedule existing visit, without 24 business hour notice, a $50 charge will be added to the patient's account and must be paid prior to rescheduling.

· A $50 charge will be added to the patients account for missed/no show visits as well.

STATEMENT OF RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I understand it's my responsibility to know the terms of my dental insurance. In compliance with the above stated terms, I agree to the following:

I read the above stipulations and agree to pay William Dental of Cincinnati in full without regard to insurance coverage, whether I sign as a responsible party or as a patient

I agree to pay any collection fees as stated above should these means of collections become required.

I am providing this office with complete and accurate billing information, including the not limited to current insurance card and permanent authorization number if applicable.

I will pay all applicable copays and understand patients' balance as they become due.

Signature: _____ Date: _____

WILLIAMS
DENTAL

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method:	☐	Home Phone	☐	Work Phone	☐	Wireless Phone	☐	Email	☐ Text
Preferred Contact Method for Confirmations:	☐	Home Phone	☐	Work Phone	☐	Wireless Phone	☐	Email	☐ Text
Preferred Contact Method for Recall:	☐	Home Phone	☐	Work Phone	☐	Wireless Phone	☐	Email	☐ Text
Student status if dependent over 19 (for ins)	☐	Non Student	☐	Full Time	☐	Part Time			

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Joint Replacement	☐	☐	Ulcers

Other conditions not listed above:

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

Patient/Guardian Signature

Date: 04/04/2024

_____