Hudson Valley Dental Arts, PC

Dr. Lawrence Hamburg

Date _____

Patient Name: _____ Date of Birth: _____

Social Security number: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home phone: _____

Business phone: _____

Cell phone: _____

E-mail: _____ Would you like to receive our monthly newsletter? _____

Family physician: _____

Have there been any changes to your medical history: _____

If yes, what? _____

_____

Do you have insurance? _____ YES _____ NO

(if yes, which company) _____ Employer _____

Is the insurance listed under your name? _____ YES _____ NO

If not, name: _____ Date of birth: _____

Social Security number: _____ Employer _____

Group #: _____

Referred by: _____

Person(s) responsible for this account: _____

How do you intend to pay for this visit: _____ Cash _____ Check _____ Credit card

Our mission is to deliver the finest treatment possible today, performed to your satisfaction. Payment is due at the time of treatment. If this is not convenient for you, please discuss payment options with our office coordinator *before* treatment.

Should I default, I agree to pay 2% monthly service charges, legal fees, and/or 29% collection fees.

Signature: _____

Patient HIPAA Awareness

With my permission, Dr. Lawrence Hamburg may use and disclose protected health information (PHI) about me to carry out treatment, payment and health-care operations (TPO). Please refer to Dr. Lawrence Hamburg's Notice of Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Lawrence Hamburg reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Lawrence Hamburg may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Lawrence Hamburg may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements as long as they are marked Personal and/or Confidential.

With my permission, the office of Dr. Lawrence Hamburg may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Lawrence Hamburg restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it it bound by this agreement.

By signing this, I am allowing Dr. Lawrence Hamburg to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian Date

Print Patient's Name

Our Practice Statement

Our practice is dedicated to quality care and exceptional service. We respect the important of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments created scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we require a minimum of 24-hour notice, so that we may accommodate another patient.

A charge will be applied for broken and missed appointments without advance notification. Thank you for your cooperation in this matter.

Vital Information About Your Dental Insurance

Our office is happy to help file your insurance to receive benefits for which you and your employer are paying premiums. Dental benefit plans can vary from company to company with different procedures and not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductible and co-payments are typically built in to most plans and their requirement payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductible and co-payments are not collected. Your employee benefits director can usually help you before familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of your treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60-day period.

Your responsibilities:

1. To pay fees not covered by your plan at the time of treatment,
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance after 2 billing attempts, within 60 days of service.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign the form below. We will keep one copy in your chart and will give you a copy for your own records.

Note: If you use a coupon or other fee-reducing offer, we must submit to your insurance company the actual amount paid, not the value of the service before the discount was applied.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third-party payers.

_____ _____

Patient or Insured Date