

HOW DID YOU HEAR ABOUT US?

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Walk-in / Drive by | <input type="checkbox"/> Sign/Banner | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Doctor's Referral Who? _____ |
| <input type="checkbox"/> Newspaper Ads | <input type="checkbox"/> Flyer | <input type="checkbox"/> Friend/Family Referral, Who? _____* |
| <input type="checkbox"/> Magazine Ads | <input type="checkbox"/> Website | <i>* your family or friend will receive free gifts from us!</i> |

“What was it about the advertisement that caught your attention?” _____

Are you a student? Full Time* Part Time* No *Please provide a copy of your student ID

Would you like to receive a postcard reminding you of the 6-month exam and cleaning? YES NO

Please provide your email address so we can send you reminder of your appointment _____

NOTICE OF PRIVACY PRACTICES

We recognize that patients have the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information. By signing the acknowledgement below, you are confirming that you have received and read our Privacy Practices. If, for any reason, you would like to have your record transferred, there will be duplication fees of \$25 dollars. I also give doctor the permission to take X-rays and perform an examination for me. I will inform the doctor, if for any reason, I can not take X-rays (e.g. Pregnancy)

X _____

Signature of Patient / Responsible Party

X _____

Date

PERMISSION FOR X-RAYS

I am not pregnant or possibly be pregnant. I gave A Tender Dental Care permission to take all the necessary x-Rays.

X _____

Signature of Patient / Responsible Party

X _____

Date

OUR POLICY OF CARE AND PAYMENT

Our practice is committed to provide highest quality dental care. Payment is due at the time of treatment.

As courtesy to our patients, we submit dental claims to your insurance company for payment. Patient's insurance coverage is a contract between patient's employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. We must emphasize that as dental care providers, our relationship is with you, and not your insurance company. We ask that each patient pay their deductible and their estimated portion of the charges at the time of services. If, for any reason, your insurance company does not pay the estimated amount within 60 days, it becomes your financial responsibility.

Our practice is committed in providing the best treatment possible for our patients and we charge what is Usual and Customary Rates for our area. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates. In effort to maintain our excellent service, a \$55.00 charge will be made for missed appointments that are not cancelled or rescheduled 24 hours prior to the scheduled appointment time. Please indicate below the form of payment you choose to settle your account:

- Cash
- Visa or Master Card
- CareCredit Payment Plan (Subject to credit approval, available to uninsured patient only)

I have read, understand, and agree to the above Financial Policy regarding my payment and insurance obligations. I will notify A+ Tender Dental Care if any changes in insurance, address, or phone number occur.

X _____

Signature of Patient/Responsible Party

X _____

Date