

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information If you have dental insurance, please complete.

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ SS/ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ SS/ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

I hereby give my consent to Bucks County Smiles including Dr. Howard Hopenwasser, Dr. David Faust, Dr. Jonathan Glatt and their staff, to perform dental treatment on _____ Myself _____ My Dependent (Name: _____). I understand that X-rays will be taken if needed for proper and thorough diagnosis prior to the onset of treatment. I agree to speak to the dentist about dental procedures, costs and appointments should I have any questions.

Signature of patient, parent or guardian _____ Date: _____

Relationship to Patient: _____



Dear Patient,

With regard to payment for services provided here in our dental office, we would like to explain our policies. What we ask is for you to pay for your treatment at the time of your dental visit. If your charges are in excess of \$400, and you pay in full with a check or cash, we will extend a 5% bookkeeping courtesy to you. If you have insurance, we would be happy to submit a claim for you as the process should be expedited due to our electronic billing process. The insurance company should then reimburse you. We accept cash, personal check, Visa, Master Card, Discover and American Express.

If payment up front is a hardship for you, and you have insurance, we will then submit a claim to your insurance and have them pay our office directly. The balance after insurance will then be charged to the credit card you have authorized us to use. Please note that in the case of a large treatment plan, we also offer a 0% finance option over three or six months, pending approval. The benefit cannot be used in conjunction with any other discounts or courtesies. If financing is necessary, we will extend payment through Wells Fargo Financing with approved application.

Unfortunately, some insurance companies exploit the payment system and take much longer than necessary to pay on dental claims. We would be more than happy to submit your dental claims for you but we are asking for your cooperation by paying for services as they are rendered. Please be aware that your insurance policy is contract between you and your insurance company. We cannot guarantee payment of the claim. Professional services are rendered and charged to the patient, not to the insurance carrier. Should your claim be rejected or only partially paid, your insurance company should send you an explanation of benefits. Ultimately, financial liability is your responsibility.

Please be sure to furnish us with a completed insurance form for each member of your family for each new year. Even with electronic submissions, it is a requirement for us to have your signature and all current information on file. If you would like assistance in fully understanding your insurance coverage, your personnel director should be able to supply this information. If you bring us your policy book, we would be glad to aid you in understanding this information.

Appointments cancelled with less than 24 hours notice are subject to a \$25 cancellation charge per half hour. Checks returned by your bank are subject to a \$25 processing charge. Accounts unpaid after 30 days from the date of billing, are subject to a finance charge at the rate of 1 ½% per month. If your account is referred for collection, you will be responsible for collection costs and reasonable attorney's fees.

Thank you for your cooperation regarding our written policy. We will do our very best to provide you with the best quality dental care possible.

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF BUCKS COUNTY SMILES.

SIGNATURE OF PATIENT OR GUARDIAN

DATE