COSIMI
DENTAL IMPLANTS & PERIODONTICS

Cosimi Dental Implants & Periodontics

Patient Registration

Date _____

Patient's Name _____
Last First Middle

If patient is under age 18, give parent's or guardian's name _____

Mailing Address _____
Address City State Zip

Email:_____ Home Ph. _____ Cell Ph. _____Work Ph: _____
___

SSN: _____ Date of Birth: _____ Marital Status: S M D W Gender: M F

Best number to call you ?_____ May we leave a detailed message at this number? Yes No

Employer _____Occupation_____

Spouse's Name _____
Last First Middle

Spouse's Employer _____Spouse's Occupation_____

Is an immediate family member a patient here? _____ Name _____

Whom may we thank for referring you to our office?

Responsible Party Information (The responsible party MUST be present at all appointments and sign all documents.)
Self __ Yes/No Other If "other" please complete

Name_____
Last First Middle Birth date

Social Sec. # _____ Birth Date____/____/_____ Relationship to Patient _____

Address _____
Street City State Zip

Home Ph. _____ Cell Ph. _____ Work Ph. _____

Dental Insurance Information

Insured's Name _____ Birth Date____/_____/_____

Insured's Employer _____Insurance Company_____
_____

Ins. Dental Claims Ph # _____Group No. _____ I.D. No. _____

Insurance Co. Address _____
Do you have any dual coverage? Yes No If yes, list primary _____

Insured's Name _____ Insured's ID. # _____ Birth Date _ / /

Insurance Company_____ Ins. Dental Claims Ph # _____Group No. _____

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Emergency Contact Information (other than yourself) * REQUIRED *

Name _____

Address _____
Street City State Zip

Phone No. _____ Relationship_____

Reason for today's visit _____

1. Are you having pain or discomfort at this time?..... Yes No
2. Have you been a patient in the hospital during the past two years?.....Yes No
3. Have you been under the care of a medical doctor during the past two years?.....Yes No

   Physician's Name _____

   Address _____ Telephone _____
4. Have you taken any medication or drugs during the past two years?..... Yes No
5. Are you now taking any medication, drugs, or pills?..... Yes No

   If yes, please list: _____

   _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substances?..... Yes No

   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Murmur…….	Yes No			Diabetes…….	Yes No		
Heart Pacemaker……..…	Yes No	Hepatitis A (infectious)……	Yes No	Thyroid Problems…….	Yes No		
Mitral Valve Prolapse……	Yes No	Hepatitis B (serum)…….	Yes No	Tuberculosis…….	Yes No		
High Blood Pressure……..	Yes No	Hepatitis C…….…….	Yes No	Asthma…….	Yes No		
Heart Surgery…….	Yes No	A.I.D.S…..…….….	Yes No	Artificial Joints……	Yes No		
Rheumatic Fever……	Yes No	H.I.V. Positive…….……..	Yes No	Psychiatric Treatment….	Yes No		
Epilepsy or Seizures……..	Yes No	Bleeding Problems / Hemophilia…..	.Yes No	Cortisone Medicine……	Yes No		
Fainting or Dizzy Spells……	Yes No	Radiation Therapy……..……	Yes No	Cancer…….	Yes No		

Other:_____

8. Do you Smoke? Yes No If yes: # of packs per day _____; # of cigarettes per day_____

9. Do you use Smokeless Tobacco? Yes No 10. Do you take aspirin daily? Yes No What Dose? 81 325

11. Do you require a pre-med antibiotic for dental visits? Yes No Type:_____

Reason: artificial joints heart issue's

****YOU WILL NEED TO HAVE THE DR. THAT WANTS THE PRE-MED TO PRESCRIBE FOR TODAY'S VISIT*****

12. Have you received I.V. Antiresorptive/Bisphophonate Medication (Reclast, Donusab, Prolia, Fosemax) in the past? Yes No

For what condition:

For Women Only:
Are you pregnant? ☐ Yes, due date _____ ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Pharmacy:
Location:
Phone #:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date_____

Consent:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.
ANY PORTION OF A REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE SENT TO A COLLECTION AGENCY.

Patient_____Date_____

Witness_____

Parent or Responsible Party_____

Relationship to Patient_____

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For Patients with Medicare

As a non-participating provider, in compliance with Section 1802(3)(B) of the Social Security Act, we are required to have a private contract with all Medicare beneficiaries.

Please read the following statements and sign on the line provided.

- I understand that Dr. Michael Cosimi is excluded from the Medicare program.
- I, the beneficiary, or my responsible party accepts full responsibility for payment for Dr. Cosimi's charges for all services furnished.
- I understand that Medicare limits do not apply to what Dr. Cosimi may charge for services furnished.
- I agree not to submit a claim to Medicare or ask Dr. Cosimi or his staff to submit a claim to Medicare.
- I understand that Medicare payment will not be made for any items or services furnished by Dr. Cosimi that would otherwise be covered by Medicare if there were no private contract.
- I understand that I have the right to obtain Medicare covered services from providers who have not opted out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare covered services furnished by other providers who have not opted out.
- I understand that Dr. Cosimi's current opt out agreement runs from April 2, 2015-April 2, 2017, and that he intends to keep it current thereafter.
- I understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

I, the Medicare beneficiary or his/her responsible party, have read, understand, and agree to the terms outlined in this contract.

Signature of patient or responsible party: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security # : _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Michael Cosimi

Telephone: 618/997-2403 Fax: 618/997-2487

Address: 408 Lincoln Dr.

Herrin,, IL 62948

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
NAME

office's Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Cosimi Dental Implants & Periodontics

FINANCIAL POLICY

INSURANCE

1. Patient and/or responsible parties who have dental or health insurance should remember that professional services are provided and charged to the patient/responsible party, not the insurance company. Allowing time for the insurance company to process claims before collecting our fee is a courtesy we *may* extend to our patients- not an obligation.
2. We will submit insurance claims for the patient and/or responsible party unless other arrangements have been made.
3. We will ESTIMATE, to the best of our ability, the amount your insurance company will pay. We ask that you pay the difference between ESTIMATED coverage and the cost of the procedure at the time of service.
4. Should insurance pay more than the estimated amount, our office will gladly refund the difference.
5. Insurance companies pay benefits based on fees that they determine according to contracts negotiated with employers and/or individuals. They term these benefits "reasonable and customary rated" which may or may not be the prevailing fees in the area. The fees charged in our practice fall within most insurance company's "reasonable and customary rates". However, those who have a contract with a lesser quality insurance company, or those whose employers have purchased inferior plans may have "reasonable and customary rates" that fall below actual charges. Should this occur, the patient and/or responsible party is liable for the balance not covered by insurance. We will not be forced to let monetary considerations and insurance company policies interfere with providing the best possible care to our patients.
6. If a patient's insurance requires hospitalization to be predetermined, it is the patient's responsibility to notify our office.
7. The parent that accompanies a minor to the office will be responsible for the fees unless other arrangements have been made prior to the date of service.
8. (For DELTA Premier patients) Sixty days will be allowed for your insurance company to process the claim. If, after sixty days, no notice has been received from your insurance company, it is your responsibility to contact them directly. Regarding your insurance, you should remember that the entire balance is your responsibility at that time.

LATE FEES AND/OR COLLECTION COSTS

1. If any balance is overdue and legal or Collection assistance becomes necessary, the responsible party (guarantor) will be liable for charges incurred.
2. **We require you to give us at least 24 hours notice if you need to cancel your appointment to avoid cancelation fees. Same day cancelation for all appointments- $50.00 fee. No call no show- $50.00 fee.**

This signature is on file as my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Dr. Michael Cosimi/Cosimi Dental Implants & Periodontics, of the insurance benefits otherwise due me.

I have read the above financial policy and agree to the terms outlined therein.

Patient/Parent, Guarantor or Legal Guardian _____ Date _____