ANTI-KICKBACK LETTER

Dear Patient:

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances on the date of service.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payment please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,

Memorial Drive Dental Associates

1176 Memorial Drive, Chicopee, MA 01020 (413) 593-5772

MISCELLAENOUS DISCLOSURES

PLEASE BE ADVISED OF THE FOLLOWING:

SOME INSURANCE COMPANIES ARE NOT PAYING 100% TOWARDS ROUTINE PRVENTIVE SERVICES (CLEANING, EXAMS AND XRAYS).
THE MAJORITY OF INSURANCE COMPANIES WILL NOT PAY THE EXPENSE OF A RESIN FILLING (WHITE FILLING) ON POSTERIOR TEETH (PRE-MOLARS AND MOLARS). THE INSURANCE COMPANIES DOWN GRADE THE TREATMENT TO AN AMALGAM FILLING WHICH IS SUBSTANTIALLY CHEAPER THAN A RESIN. YOU ARE RESPONISBLE FOR THE BALANCE UP TO OUR SUBMITTED FEE.
A PRE-ESTIMATE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT. THEY HAVE THE RIGHT TO DOWN GRADE THE PROCEDURE TO A CHEAPER ALTERNATIVE IF THEY BELIEVE THE CHEAPER ALTERNATIVE WAS SUFFICIENT ENOUGH (IE. YOU WOULD LIKE A FIXED PROSTHETIC (BRIDGE) THE INSURANCE COMPANY CAN AT ITS OPTION DOWN GRADE IT TO A PARTIAL THAT IS REMOVABLE.
OUR TREATMENT PLANS ARE BASED ON AN AVERAGE OF NUMEROUS INSURANCE PLANS AND ARE INTENDED TO BE A ROUGH ESTIMATE OF YOUR PAYMENT.
WE RESERVE THE RIGHT TO TERMINATE ANY PATIENT THAT REFUSES TO HAVE RADIOGRAPHS (XRAYS). RADIOGRAPHS ARE AN IMPORTANT TOOL TO MAINTAIN A HEALTHY ORAL CAVITY.

DATE______________________________ ____________________________

PATIENT/GUARDIAN SIGNATURE

WELCOME TO OUR PRACTICE

Patient Information

Date

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

First Name | M.I. | Last Name | Preferred

Sex: ☐ Male ☐ Female

Birth Date

Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Address | City | State | Zip

Home Tel. | Cell | Work | Ext

Email | Social Security Number

How did you learn of our office?

Appt Preference: ☐ None ☐ AM ☐ PM On Short Notice? ☐ Yes ☐ No

Patient Is: ☐ Patient ☐ Policy Holder ☐ Responsible Party

Office Can Send Me: ☐ Emails ☐ Texts ☐ Appointment Reminders

Employed: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ N/A

School Name

Student: ☐ Full-Time ☐ Part-Time ☐ N/A

Address | City | State | Zip

In Case of emergency, please contact | Tel. | Relation

Who is responsible for your account

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other

First Name | Last Name | Birth Date | Tel.

Address | City | State | Zip

S.S. # | Employer

Insurance Information

Do you have insurance? ☐ Yes ☐ No

Primary Insurance Company

Insurance Type: ☐ Dental ☐ Medical

Employer

Ins. Co. Name | I.D. #

Address | City | State | Zip

Group # | Group Name

Pol. Holder First Name | Pol. Holder Last Name | Relation

Birth Date | S.S. #

Address | City | State, Zip | Tel.

Secondary Insurance Company

Insurance Type: ☐ Dental ☐ Medical

Employer

Ins. Co. Name | I.D. #

Address | City | State | Zip

Group # | Group Name

Pol. Holder First Name | Pol. Holder Last Name | Relation

Birth Date | S.S. #

Address | City | State, Zip | Tel.

Dental Information

Reason for today's visit

Are you in pain? ☐ Yes ☐ No

For How Long?

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ A removable dental appliance
- ☐ Blisters / sores in or around the mouth
- ☐ Prolonged bleeding from an injury / extraction
- ☐ Recent infections or sore throat
- ☐ Lost / broken filling(s)
- ☐ Teeth grinding / clenching
- ☐ Ringing in ears
- ☐ Broken / chipped tooth
- ☐ Gum disease
- ☐ Other
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Burning tongue / lips
- ☐ Toothache
- ☐ Difficulty closing jaw
- ☐ Difficulty opening jaw
- ☐ Loose / shifting teeth
- ☐ Food caught between teeth
- ☐ Swelling / lumps in mouth

My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

Are you undergoing ortho? ☐ Yes ☐ No

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of patient (Parent or Guardian if Minor)

Date

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices.
I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

Signature of patient (Parent or Guardian if Minor)

Date

Medical History

First Name | Last Name | Birth Date | Date

Are you under the care of a physician? ☐ Yes ☐ No If yes, explain below

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, explain below

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, explain below

Are you taking any medications,pills or drugs? ☐ Yes ☐ No If yes, complete the medications section at the end

Do you take or have taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, explain below

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, explain below

Are you on a special diet? ☐ Yes ☐ No If yes, explain below

Do you use tobacco? ☐ Yes ☐ No If yes, explain below

Do you use controlled substances? ☐ Yes ☐ No If yes, explain below

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment? ☐ Yes ☐ No If yes, explain below

Women: Are You...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetic

Do you have or have you had any of the following diseases or medical conditions?

Y N		Y N		Y N		Y N	
☐ ☐	AIDS/HIV Positive	☐ ☐	Cortisone Medicine	☐ ☐	Hemophilia	☐ ☐	Radiation Treatments
☐ ☐	Alzheimer's Disease	☐ ☐	Diabetes	☐ ☐	Hepatitis A	☐ ☐	Recent Weight Loss
☐ ☐	Anaphylaxis	☐ ☐	Drug Addiction	☐ ☐	Hepatitis B or C	☐ ☐	Renal Dialysis
☐ ☐	Anemia	☐ ☐	Easily Winded	☐ ☐	Herpes	☐ ☐	Rheumatic Fever
☐ ☐	Angina	☐ ☐	Emphysema	☐ ☐	High Blood Pressure	☐ ☐	Rheumatism
☐ ☐	Arthritis/Gout	☐ ☐	Epilepsy or Seizures	☐ ☐	High Cholesterol	☐ ☐	Scarlet Fever
☐ ☐	Artificial Heart Valve	☐ ☐	Excessive Bleeding	☐ ☐	Hives or Rash	☐ ☐	Shingles
☐ ☐	Artificial Joint	☐ ☐	Excessive Thirst	☐ ☐	Hypoglycemia	☐ ☐	Sickle Cell Disease
☐ ☐	Asthma	☐ ☐	Fainting Spells/Dizziness	☐ ☐	Irregular Heartbeat	☐ ☐	Sinus Trouble
☐ ☐	Blood Disease	☐ ☐	Frequent Cough	☐ ☐	Kidney Problems	☐ ☐	Spina Bifida
☐ ☐	Blood Transfusion	☐ ☐	Frequent Diarrhea	☐ ☐	Leukemia	☐ ☐	Stomach/Intestinal Disease
☐ ☐	Breathing Problem	☐ ☐	Frequent Headaches	☐ ☐	Liver Disease	☐ ☐	Stroke
☐ ☐	Bruise Easily	☐ ☐	Genital Herpes	☐ ☐	Low Blood Pressure	☐ ☐	Swelling of Limbs
☐ ☐	Cancer	☐ ☐	Glaucoma	☐ ☐	Lung Disease	☐ ☐	Thyroid Disease
☐ ☐	Chemotherapy	☐ ☐	Hay Fever	☐ ☐	Mitral Valve Prolapse	☐ ☐	Tonsilitis
☐ ☐	Chest Pains	☐ ☐	Heart Attack/Failure	☐ ☐	Osteoporosis	☐ ☐	Tuberculosis
☐ ☐	Cold Sores/Fever Blisters	☐ ☐	Heart Murmur	☐ ☐	Pain in Jaw Joints	☐ ☐	Tumors or Growths
☐ ☐	Congenital Heart Disorder	☐ ☐	Heart Pacemaker	☐ ☐	Parathyroid Disease	☐ ☐	Ulcers
☐ ☐	Convulsions	☐ ☐	Heart Trouble/Disease	☐ ☐	Psychiatric Care	☐ ☐	Venereal Disease
						☐ ☐	Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments

Medications

Please list any other medication(s) you are taking

Medication	**Medication**

Please list any allergies other than drug allergies:

Do you have any known allergies? ☐ Yes ☐ No

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I consent to the diagnostic procedures and treatment by the dentist(s) of this office necessary for proper dental care.

Signature of patient (Parent or Guardian if Minor)

Date

**FINANCIAL AGREEMENT
AND POLICIES OF
MEMORIAL DRIVE DENTAL ASSOCIATES, P.C.**

We, the staff of Memorial Drive Dental Associates, P.C., thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding or fees, policies, or responsibilities please feel free to contact us at (413) 593-5772.

We believe the level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, and in-state checks). A $50.00 service fee will be charged for all returned checks. Also, any accounts that are more than 120 days overdue will be charged a 24% finance charge. Any accounts that are sent to collections will be charged a $50 collection fee, as well as a 24% finance charge.

INSURANCE

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefits under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of service does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are no contracted with your carrier we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorization

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extra curricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

Appointment Arrival Time and Missed Appointments

We ask that all existing patients please arrive at least ten (15) minutes before their scheduled appointment. We require notice of cancellation 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance: a missed appointment fee will apply. These fees are typically $50.00 but not to exceed one-half of the cost of your scheduled appointment. Three missed appointments or same day cancellation will cause you to be discharged from the practice so that we can provide care to other patients. You will be given a letter of discontinuation by regular mail.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. The fee for copying, supplies, labor and postage of the files, and or summaries is $35.00 and is due at the time of request for copies.

I have read and understand the above financial policy and policies of Memorial Drive Dental Associates. I agree to assign insurance benefits to Memorial Drive Dental Associates, P.C. whenever applicable. I also agree, in additional to the amount owed, I also will be responsible for the charged by the collection agency for costs of collection if such action becomes necessary.

Date:______________________ ______________________________

Signature of Insured or
Authorized Representative

MEMORIAL DRIVE DENTAL ASSOCIATES
ACKNOWLEDGEMENT OF HIPAA NOTICE
OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have reviewed a copy of this Dental Practice's HIPAA Notice of Privacy Practice.

____
Patient Name (Please Print)

______________________________ ______________________________
Patient Signature Date

OR

____
Signature of Personal Representatives

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other__________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of our Notice of Privacy Practices, but it could not be obtained because

☐ An emergency prevented us from obtaining acknowledgement.
☐ A communication barrier prevented us from obtaining acknowledgement
☐ The individual was unwilling to sign.
☐ Other:____

______________________________ ______________________________
Staff Member Signature Date