# **fox’s spokane denture clinic Patient REGISTRATION FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| Today’s Date:  |  |

PATIENT INFORMATIONPatient’s last name:       First:       Middle Initial       Sex:[ ]  M [ ]  F Birthdate:

|  |  |  |
| --- | --- | --- |
| Address:      | City, State       | Zip      |
| Primary Phone Number:  | Secondary Phone Number:  |  |
|  Are you a resident at a nursing home or alternative living facility or not living at home? [ ]  YES [ ]  NO  | \_\_\_\_ Herpes \_\_\_\_ HIV/ Aids \_\_\_\_\_Thrush\_\_\_\_ Hepatitis Any other conditions (please list):                 |  |
|  |  |  |

INSURANCE INFORMATION(Please give your insurance card to the receptionist.)

|  |  |  |  |
| --- | --- | --- | --- |
| Person responsible for bill:      | Birth date:      | Social Security #      | Home phone #.:      |
| Primary insurance carrier:       | Private Insurance ID# |       | Private Insurance Group # |       |  |

Patient’s relationship to subscriber:      IN CASE OF EMERGENCY

|  |  |  |
| --- | --- | --- |
| Name of local friend or relative      | Phone:      |  |
| Names of other people we can talk to or leave a message with:            |  |  |

Texting and Email reminders

|  |
| --- |
| You agree that by signing below you consent and request that Fox’s Spokane Denture Clinic, its affiliates, and those acting on its/their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include [AOF-Legal] those concerning the patient’s care, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide or we obtain even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ an automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue appointments, account balances due, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.      Initial here if you would like to receive calling, texting and email reminders.  |

office policies **Financial Policy**: When treatment is decided, policy requires, at minimum, either A) a down payment of halt the amount or B) approval of a payment plan. At the end of service, the remaining balance is due before services are delivered unless a payment plan is already in agreement. Refunds are NOT guaranteed. **Insurance Policy**: Before treatment begins, we do our best to ensure that insurance benefits are used to the best of our capability. We also attempt to get estimates for policies; however, instances do occur when the insurance company denies a claim for a variety of reason. We ask that services are paid for up front and when your insurance company pays our office will reimburse whatever that payment is. **Service Agreement:** Once services being, the patient is responsible for the entirety of the balance. A 25% (30% if implant related) non-refundable service fee applies if the patient decides to terminate services or have a change of mind. This applies during the construction and prosthetics and a 90-day grace period after delivery. **Termination Agreement**: Fox’s Spokane Denture Clinic reserves the right to refuse service or terminate treatment at any time if any staff deems a patient’s behavior to be abusive or inappropriate or if a patient repeatedly misses appointments. **Privacy Practices**: By signing below, the patient acknowledges that they have received a copy of the Statement of Privacy Practices for Fox’s Spokane Denture Clinic (FDC). The Statement of Privacy Practices describes the uses and disclosures of protected health information that might occur during treatment or payment. It also describes the rights and responsibilities of the patient and is posted in the clinic. FDC reserves the right to change privacy practices with notification to the patient. The statement is posted in the facility. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize Fox’s Spokane Denture Clinic or insurance company to release any information required to process my claims.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Patient/Guardian signature                          |  | Date           |  |

 |