



Welcome,

On behalf of my staff, I would like to welcome you and your family to our practice. Our goal is to provide you with quality care so that you may enjoy the benefits of good dental health. We offer a wide range of comprehensive services for children and adults including:

- Routine Exams and Cleanings
- Cosmetic Fillings
- Crowns, Bridges and Veneers
- Complete and Partial Dentures
- Implants and Implant Restorations
- Root Canal Therapy
- Periodontal Therapies including 'Deep Cleanings'
- Tooth Whitening
- TMD Therapy
- Nitrous Oxide Sedation
- Digital X-Rays

For certain procedures that are beyond the scope of general practice, we utilize an excellent network of specialists nearby that are ready to serve you.

Please take a moment to browse through your welcome packet. We have included an overview of our office policies, HIPAA information and new patient forms that will need to be completed before your first appointment.

Thank you for the opportunity to treat you and your family. We will do our best to exceed your expectations.

Sincerely,

L. Justin Payne, D.M.D.



Please Tell Us About Yourself

How did you hear about our office?

What is your occupation?

Are you new to the area?

Do you have certain days of the week and/or times of the day that you prefer when scheduling your dental appointments?

Would you be available on short notice for your dental appointments if we were to have a change in our schedule?

Would you like to receive correspondence such as appointment reminders by email?

Is there a specific pharmacy that you prefer to use for prescriptions?

Do you have any specific concerns or dental anxiety that you would like to share to help us customize your dental treatment?

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: ☐ Policy Holder☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient) _____

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home

Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder**Patient Information**

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home

Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: ☐ Male☐ FemaleMarital Status: ☐ Married☐ Single☐ Divorced☐ Separated☐ Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____

☐ I would like to receive correspondences via e-mail.**Section 2**Employment ☐ Full Time☐ Part Time☐ RetiredStudent Status: ☐ Full Time☐ Part Time

Medicaid ID: _____

Pref. Dentist: _____

Employer ID: _____

Pref. Pharmacy: _____

Carrier ID: _____

Pref. Hyg: _____

Section 3

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Credit card number _____

card expiration _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self☐ Spouse☐ Child☐ Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self☐ Spouse☐ Child☐ Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		

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 Anesthetics

Other? ☐ If yes

Do you use controlled substances? ☐ Yes ☐ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____



FINANCIAL POLICIES

Billing and Financial Policy

As a patient, you will receive comprehensive dental care. Our fees will be related both to the amount of time the doctor spends with you and to the level of skill required to provide each particular type of service. We ask you to be prepared to pay for each office visit at the time of visit with cash, check or credit card. A schedule of services and the fees charged for each visit is available. When situations arise in which a fee cannot be paid at the time of service, arrangements must be discussed with the office manager prior to your visit. Please understand that you are responsible for paying your bill on time regardless of the status of an insurance claim. All fees over 90 days past due will be subject to collection procedures and you may lose your eligibility to receive medical services from us. If circumstances beyond your control prevent you from being prompt in paying a bill, please contact the office as soon as possible so that a mutually acceptable plan of payment can be arranged. As a courtesy our office will be happy to file your charges for services rendered to your insurance company. If you are a participating member of a PPO plan, we will expect you to pay your co-pay and/or any other fees that are not covered at the time of your visit. If your insurance pays us directly, we will reimburse you promptly for any overpayment that has been made. **Failure to pay your deductible and co-pay at the time of service will result in a billing fee of \$25.00.** Please remember that we are contractually obligated by your insurance company to collect your co-pay at the time of service. The balance of your charges will be billed. Payment in full of patient portion will be expected with receipt of your statement. Proof of current, valid insurance must be provided at the time of service. If you do not provide this information, you will be considered a self-pay patient.

Past Due Balances

If your balance is not paid in full within 30 days, your account will be billed a \$9.00 administrative fee and a finance charge of 2% of the unpaid balance. These charges will accrue each month there is an outstanding balance. **Account balances over 90 days past due will be transferred to our collection agency.** We reserve the right to submit your personal information to any agency deemed necessary to collect the balance that is due. In the event that your account is transferred to a collection agency, your account will be assessed a collection fee of up to 38% of the remaining balance.

Dental Insurance Policy

We participate with many different dental insurance companies. In addition, each of these companies offers many different types of plans. We make every attempt to accurately estimate benefit coverage and collect copays and deductibles. Therefore, **fees quoted are an estimate based on information you provide to us about your insurance carrier, not a guarantee of payment. Understanding your dental insurance benefit is your responsibility.** Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems our services as non-covered will be billed directly for their charges. Often treatments such as composite (tooth colored) fillings, porcelain crowns, veneers, etc. will not be covered to the same degree as amalgam (silver) fillings and metal crowns by your insurance carrier. The difference in the amount covered by insurance and your account balance is your responsibility regardless of whether our office is an in-network or out-of-network provider. **Your insurance policy is contract between you and your insurance company, therefore, your balance is your responsibility. EACH PATIENT IS RESPONSIBLE FOR THE FULL AMOUNT OF THEIR ACCOUNT BALANCE, REGARDLESS OF INSURANCE COVERAGE. Please remember recommended treatment is solely based on your dental needs, not on your insurance coverage.**

Check Policy

We are happy to accept your personal check for payment towards your account balance. However, if funds are not available in your account and your check is returned to us for any reason you will be assessed a **\$30.00 service fee** plus the cost of the original check. If your check is returned to us you will be notified immediately and will have ten business days to resolve the balance with cash, cashier's check or credit card before being turned over to our collection agency. If you present two checks that are insufficient, then we will no longer accept payment by check on your account, only cash or credit card.



PATIENTS WITH DENTAL INSURANCE
PLEASE BE ADVISED

Whether our is an In-Network or Out-of-Network Provider for your dental insurance carrier, verification of your dental insurance coverage by this office is not a guarantee of payment for service provided.

Your dental insurance coverage is a contract between you and the dental insurance company. Our staff will gladly assist you in understanding your dental coverage, but you are responsible for understanding your dental insurance. **Verification of dental coverage and acquiring an estimate of benefits (EOB) for various dental procedures is solely the patient's responsibility.**

Deductible and Co-Pay is due in-full at the time services are rendered.

Denial of coverage by your dental insurance carrier or failure of your insurance carrier to pay the full amount of their portion for service rendered is not the responsibility of Dr. Payne or his staff.

EACH PATIENT IS RESPONSIBLE FOR THE FULL AMOUNT OF THEIR ACCOUNT BALANCE, REGARDLESS OF INSURANCE COVERAGE.



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FAMILY AND COSMETIC DENTISTRY

CANCELLED & FAILED APPOINTMENTS

In order to provide you and your family with the best dental care possible it is very important that you are present for scheduled appointments. If you cannot keep your appointment with us, please notify us as soon as possible. We will be happy to reschedule your appointment for a time more convenient for you as our schedule allows.

All cancellations made less than 24 hours before your scheduled appointment time and all missed appointments will have a \$40 MISSED APPOINTMENT FEE charged to your account. This \$40 fee is not covered by your insurance carrier and must be paid before you will be seen at your next appointment.

If a patient or patient's family has missed or cancelled numerous appointments we reserve the right to stop providing dental treatment to these patients and excuse them from our practice.



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Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military



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purposes; or for the evaluation and health of members of the foreign service;

- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we



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do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.



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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA

I acknowledge I have received a copy of L. Justin Payne, DMD, PC's Notice of Privacy Practices (HIPAA). I also certify that I have read and understand the Notice of Privacy Practices to the best of my knowledge and I understand that more information is available upon request. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.

Patients Full Name: _____ Date: _____

Parent or Guardian Full Name If Patient is a Minor: _____

Signature: _____

Acknowledgement of Receipt of Office Billing and Financial Policies

I acknowledge I have received a copy of the Office Financial Policy and Cancellation policy. I further acknowledge that I have read and understand these Policies. Furthermore, I understand that I may ask for additional assistance at any time from the staff of L. Justin Payne, DMD. I understand that I am fully and solely responsible for any account balance due, regardless of insurance status or any denial of payment by my insurance carrier for any portion of their estimated coverage. I understand it is solely my responsible to verify that my dental insurance coverage is current and to contact my dental insurance carrier to verify coverage and co-pay information for specific procedures (crowns, fillings, extraction, cleanings, root canal therapy, etc.) once these procedures have been planned and before treatment is rendered using dental codes provided to me by L. Justin Payne, DMD, PC on my printed treatment plan.

Patients Full Name: _____ Date: _____

Parent or Guardian Full Name If Patient is a Minor: _____

Signature: _____