CROSSROADS
FAMILY DENTISTRY
Your Smile, Our Passion!

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address: _____

City, State, Zip_____

Home phone _____ Cell phone _____E-mail_____

May we text you to confirm/schedule appts? Y N May we e-mail you to confirm/schedule appts. Y N

Patient Social Security Number _____ Date of Birth_____

Marital Status: Single Married Widowed Divorced

Emergency Contact _____ Phone _____

Preferred Pharmacy_____ Phone # _____

How did you hear about us? Radio Post Card Internet Fam/Friend_____ Other (please list) _____

Do you have Dental Insurance? Yes No Subscriber Name (who carries insurance) _____

Subscriber ID or SSN _____ Subscriber 's Date of Birth _____

Relationship to Subscriber: Self Spouse Child Other

Employer Name _____ Insurance Company _____

Insurance Group # _____ Insurance Phone # _____

Please present your Insurance card and Photo ID at your appointment to be photocopied.

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Financial Agreement

Thank you for choosing our dental practice. Dental treatment is an excellent investment in an individual's overall well-being. We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time.

Payment is expected at the time of service. Payments can be made by cash, check or credit card. We also offer Care Credit Financing for qualified applicants with up to 12 months free financing. An application may be filled out in the office or you can apply online at www.carecredit.com.

Insurance - For our patients with dental insurance, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the **insurance company** and the **patient**. As such, **we cannot make a guarantee of estimated coverage or payment**. However, please know that we will do everything possible to see that you receive the full benefits of your policy. If the patient's insurance fails to make full payment after 60 days, the patient is responsible to pay the outstanding balance on his/her account.

Flex Plan / Spending Accounts - Payment in full is expected at the time your service is rendered. We will be happy to give you a copy of your receipt which will allow you to submit the amount to your Flex Plan/ Spending Account for reimbursement directly to you.

Short Notice Cancellations- If there has not been a reasonable amount of time given prior to your cancellation, a fee may be charged to your account. We reserve the right to charge and collect fees for appointments that are cancelled or broken without 24 hours notice. Appointments are reserved specifically for you. If cancelled or failed, the time is taken away from other patients who are waiting to be placed in our schedule. A fee of $75 for the first and $100 for the second failed appointment will be charged to your account.

Returned Check Fee - $50 will be added to your account balance if a check is returned to us as Non-Sufficient Funds (NSF).

I accept full responsibility for all treatment performed by Dr. Kumar. I understand payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement between myself and my insurance company. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all costs of collection including, but not limited to, attorney fees and court costs.

Signature of Patient, Parent or Guardian, or Responsible party Date

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Witness

CROSSROADS FAMILY DENTISTRY

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Crossroads Family Dentistry
702 W Trafalgar Pointe Way
Trafalgar, IN, 46181

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of HIPAA Receipt Family Dentistry *HIPAA Notice of Privacy Practices*.

I understand that Crossroads Family Dentistry's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Crossroads Family Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Crossroads Family Dentistry's *HIPAA Notice of Privacy Practices*, I may contact the Office Manager.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Crossroads Family Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Crossroads Family Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the Office Manager for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Crossroads Family Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Crossroads Family Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

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Photo Consent Form

I consent to Dr. Pooja Kumar and staff to take photos as part of my dental records. The photos taken at Crossraods Family Dentistry will be used to submitting dental claims to insurance company, to help you, the patient see areas of concern, and sent to any speciality Dentists that you may be referred to. We will not share or use your photograph for anything other than your chart without your permission.

Signature_____ Date_____

Information Release Form

Crossroads Family Dentistry requires that our staff obtain authorization from all patient to release and/or leave a detailed message for the patient. Secondary to the new HIPAA guidelines we need to guard against violating any patient confidentiality and protect our staff.

By signing below, I give my consent to Dr. Pooja Kumar and staff to leave messages regarding my care and/or upcoming appointments on my home or personal cell phone.

Signature_____ Date _____