FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth_____

PAYMENTS:

The estimate of fees by our office in your **treatment plan** is to be considered as a conservative guideline. There may be moderate increases or decreases in the fees, depending on your treatment needs. Payment for charges is due at the time of service. **One third of CO PAYMENT is required in ADVANCE, PRIOR to the procedure being scheduled, for ALL major dental treatment (crown, bridge, partial or full dentures) fabricated by a laboratory and oral surgery.** The forms of payment we accept include: **Visa, MasterCard, Discover, American Express, Debit Card, Personal Check with valid ID or cash.**

DENTAL INSURANCE:

Dental insurance information must be provided to our office for determination of coverage and benefits. Our acceptance does not absolve the responsibility for charges for treatment rendered. Insurance is a contract between your employer, the insurance company and you, our patient. **Most dental benefits do not cover the full cost of care.** Any unpaid portion is the patient's responsibility, due upon receipt of the insurance explanation of benefits or our billing statement. Many insurance plans have exclusions, limitations and alternate benefits that are set by your insurance company and make the proper processing of your insurance claim confusing and difficult. As a courtesy for patients with insurance benefits, we will collect our **best estimate** of your portion of the current charges (including any applicable co-payments and/or deductible) for that day's service. We calculate your co-payments according to the information we gather from your insurance company. We take great pride in helping you receive the **maximum benefit** from your insurance carrier. Our office makes every effort to be accurate in our estimation of benefits by calling your insurance company to verify eligibility, coverage and benefits. However, since there is no way to be sure benefits have not been used in other offices, or that the policy is in effect at the time of service, **our office can make no guarantee of the insurance payment as estimated.** Please address any questions regarding the explanation of benefits to your insurance carrier(s) or employer's plan administrator. Claims are submitted promptly after treatment is rendered. If your insurance hasn't paid 45 days of submitted charges, the charges will be considered your responsibility and payment in full is expected from the responsible party. **FULL PAYMENT is required of copayments, PRIOR to the completion of any procedure labeled by your insurance company as MAJOR treatment (crown, bridge, inlay, onlay, partial or full denture). FULL PAYMENT at the doctor's private practice fee schedule is required in ADVANCE, PRIOR to the procedure or evaluation, when your insurance benefits cannot be verified such as emergency after hours visits.** When your insurance benefits are verified, a claim will be processed and any credit will be applied to your account for future treatment.

BILLING:

All accounts are to be paid in full within 30 days of treatment regardless of insurance benefits. In the event an account becomes over 90 days delinquent, I understand that **Dr. Schimon** will refer my account to small claims court. If this action is necessary, I agree to pay all additional collection fees, in addition to my account balance. It is my responsibility to follow up with my insurance to make sure payment has been made to **Dr. Schimon** in a timely fashion. I also understand additional late fees of $3.00 plus 1.5% per billing cycle may be applied if my payment is not received within 15 days of the statement. **There is a minimum $35 fee added to all returned checks.** Account credits will remain on account for future treatment.

APPOINTMENT POLICY:

Our **private practice** is growing as many new patients are discovering our attention to detail and compassionate care. Therefore, **scheduled appointments are specifically reserved for you.** We will help remind you of your appointment by contacting your preferred telephone number on record to confirm a scheduled appointment, 24 hours in advance. If we do not speak with you directly, we will leave a voicemail reminder. We will charge $35 for all failed scheduled appointments.

I the undersigned, in consideration for services rendered to the patient by **Dr. Schimon**, have read, understand and agree to the terms of this ***Financial Agreement.*** All of my questions and concerns have been satisfactorily answered and addresses.

Patient's Signature:_____ **Date:** _____

Ultimate Family Dental
7485 N. Genesee Rd., P.O. Box 189, Genesee, MI 48437

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FINANCIAL RESPONSIBILITIES AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive you maximum allowable benefits. However, due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy of each of the hundreds of policies that are available. Although we try to stay aware of these changes, it is not always possible to know every change. Therefore, we urge you, as the patient, to please check with your insurance company for any changes prior to any office procedure. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Also, understand that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that will not be covered. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. ***It is your responsibility to know your insurance coverage.*** Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember that your insurance policy is between you and your insurance company and not between the insurance company and your doctor. Our contract is not with the insurance company, but rather with the patient the services are being provided to.

Payments for services are due at the time services are rendered, this includes all copayments and deductibles. We accept cash, check, and all major credit cards.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you have any questions about the above information or are uncertain regarding your insurance coverage, PLEASE, do not hesitate to ask us. We are here to help.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for my account the balance on my account for any professional services rendered. _____

I consent to treatment by Dr. Schimon and his team for myself and/or my child(ren). I have been provided the practice's statement regarding use and disclosure of my protected health information. I understand that I many have a copy of this statement if I request it from the Office Manager.

I authorize the release of any information necessary to process my claims and authorize payment to Dr. R. Fred Schimon.

You signature below verifies that you have read and understand all of the above information and that all your questions have been answered.

Signature_____ Date_____

Witness_____

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____ Business Phone _____

Business Address _____ Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____ Soc. Sec.# _____
Last Name First Name Initial

Birthdate _____ Relation to Patient _____

Address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____ Business Phone _____

Business Address _____ Business Email _____

Insurance Company _____ Contract # _____ Group # _____ Subscriber # _____

Insurance Phone _____ Insurance Email _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Soc. Sec. # _____
Last Name First Name Initial

Birthdate _____ Relation to Patient _____

Address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____ Business Email _____

Insurance Company _____ Contract # _____ Group # _____ Subscriber # _____

Insurance Phone _____ Insurance Email _____

Name of other dependents under this plan _____

Dental History

What would you like us to do today?_____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care_____ Date of last X-rays _____

Check Y for yes or N for no if you have/have not had the following:

☐Y ☐N Bad breath	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal treatment	☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold	☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot	☐Y ☐N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Medical History

Physician's name _____ Address_____ Phone _____

Physician's Email _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N If yes, describe_____

Are you currently under physician care? ☐Y ☐N If yes, describe_____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check (✓) whether you have had or currently have any of the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Alcohol/Drug Abuse
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Cholesterol problems
☐Y ☐N Chemotherapy
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe_____
☐Y ☐N Hemophilia/
Abnormal Bleeding
☐Y ☐N Hereditary Problems
☐Y ☐N Herpes
☐Y ☐N Hepatitis
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease
or malfunction
☐Y ☐N Liver disease
☐Y ☐N Material allergies (latex,
wool, metal, chemicals)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N Seizures
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Skin rash
☐Y ☐N Spina bifida
☐Y ☐N Stroke
☐Y ☐N Surgical implant
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease
or malfunction
☐Y ☐N Tobacco habit
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Ulcer/Colitis
☐Y ☐N Venereal disease

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.