Christensen
FAMILY DENTISTRY, PLC

Patient Information

Patient Name: _____ Date: _____
Last First MI

Male: ___ Female: ____ Married: ___ Single: ___ Child: ___ Other: ___

Social Security #: _____- _____- _____ Date of Birth: _____

Home Ph: _____ Cell Ph: _____ Best # to call:_____

Address:_____
Street Apt/Unit#:

_____
City State Zip Code

Whom may we thank for referring you to our practice: _____

Insurance Information

Primary Insurance

Insurance Company Name: _____ Insurance Phone # _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Member ID or Policy Holder's SSN: _____ Group Number: _____

Patient's Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance

Insurance Company Name: _____ Insurance Phone # _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Member ID or Policy Holder's SSN: _____ Group Number: _____

Patient's Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Financial Policy

Welcome, and thank you for choosing Christensen Family Dentistry. We value our patients deeply and are grateful for your business. Our goal is to provide the best possible dental care for you and want you to always feel welcome and comfortable in our office. Part of this includes making sure that our financial policy is clear and understandable. We encourage you to ask questions, and to be involved in treatment decisions. Please review our financial policy below and let us know if you have any questions.

Financial Agreement:

Patients are expected to pay for our services at the time they are rendered unless prior arrangements have been made and accepted. Those who have dental insurance are expected to pay their estimated coinsurance and deductible at the time of service, when applicable.

Important note for those using insurance: All insurance and patient portion quotes given verbally or via treatment plan are estimates based on information available at the time of service and are not guaranteed. When we receive a final EOB from your insurance, if there are any differences from what was originally quoted, an invoice will be mailed to the patient for the balance due or will notify them of a credit on their account.

Any balance on your account must be paid for before further treatment is rendered.

Accepted Payment Methods:

1. Cash, Check, Visa, Mastercard, and/or Discover: For those who do not have insurance, a 10% discount will be applied to all services.
2. Care Credit: Due to the application fees charged to our office by care credit, no discount can be applied to services. However, this option does offer payment plans with no interest. If you are interested in this option, speak with the front desk to learn how to apply.

By signing below I am acknowledging that I have read and accept the financial policy for:
Christensen Family Dentistry

_____

Patient/ Legally Authorized Individual Signature Date

_____

Printed Name Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm your appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____