

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City,

State

Zip Code

Phone

Acknowledgement of Receipt of Notice of Privacy Practices: _____ **I have received a copy of this office's Notice of Privacy Practices.** (initial)

Signature On File Authorization: I authorize Franklin Periodontics to use my name on any claims or documents that relate to Dental Insurance benefits due to me and my dependents. I authorize the release of any information related to any claims to all my Dental Insurance Companies. I authorize Franklin Periodontics to act as my agent in helping me obtain payment from my Dental Insurance Companies. I authorize payment of Dental Benefits otherwise payable to be, directly to Dr. Franklin. I permit a copy of this authorization to be used in place of an original. Signature on file is valid until I notify Franklin Periodontics in writing to cancel.

Signature of Patient: _____ **Date:** _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or credit card at the time services are performed.

Patients who carry dental insurance understand that our relationship is with the patient not the insurance company. Please note that this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A Pre-treatment estimate may be requested to determine an estimate of the patient's coordination of benefits. The patient or guardian is personally responsible for payment of all services. This office will ESTIMATE the patient's co-insurance (which is due at time of or prior to treatment) and submit insurance claim forms for reimbursement of the balance to be applied to patient account. Patient is fully responsible for payments not reimbursed by insurance company that have either denied services performed or delayed payment greater than 60 days. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or as per written agreed upon financial agreement. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____