

David Langer DMD

PATIENT WELCOME PACKET

Full Name: _____ Preferred Name: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Home Phone: _____

Birth date: _____ Social Security #: _____

E-mail: _____ I would like to receive email correspondences

Previous Dentist: _____ How did you hear about us? _____

Emergency Contact

Name: _____ Relation to Patient: _____

Primary #: _____ Secondary #: _____

Name: _____ Relation to Patient: _____

Primary #: _____ Secondary #: _____

Policy Holder/ Responsible Party Information (if different from patient):

Full Name: _____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other _____

Social Security #: _____ Zip Code: _____ Sex: Female Male

Employer ID: _____ Group Number: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Full Name: _____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other _____

Social Security #: _____ Zip Code: _____ Sex: Female Male

Employer ID: _____ Group Number: _____

Employer: _____ Insurance Company: _____

CANCELLATION & CONFIRMATION POLICY

We understand that unforeseen circumstances may arise, but we kindly ask for at least 48 business hours' notice if you need to cancel or reschedule your appointment. It is the patient's responsibility to contact our office directly to make any scheduling changes.

If notice is not provided or you fail to show for your appointment, a **\$50 broken appointment fee will be charged**. This fee must be paid before rescheduling any future appointments. Our goal is to ensure that all patients receive the care they need in a timely manner, and missed appointments take valuable time away from other patients.

Additionally, if a patient misses or cancels an appointment without proper notice more than three times within an 18-month period, they will only be able to schedule on a same-day basis moving forward.

As a courtesy, our office will send a text, email, or phone call reminder two business days before your appointment. Please ensure we have your most up-to-date contact information. If you prefer to opt out of text or email reminders, kindly notify our office, and we will provide a phone call reminder instead.

We appreciate your cooperation in keeping your scheduled appointments and look forward to providing you with excellent care!

Signature: _____ Date ____/____/____

OFFICE PAYMENT & INSURANCE POLICY

At our office, we strive to provide high-quality care while maintaining transparent financial policies. Please review the following guidelines regarding payment and insurance:

Payment Expectations

- **Payment is due at the time of service.** We accept **cash, checks, Care Credit and all major credit cards** for your convenience.
- For **extensive treatment plans**, financial arrangements **must be made in advance**, prior to the date services are rendered.
- **Balances over 30 days must be paid in full before scheduling any additional appointments.**

Insurance & Billing

- We accept insurance **on assignment**, meaning we will file claims on your behalf. However, you must pay your **deductible and any patient portion** at the time of service.
- Your **estimated** portion is due at the time of your visit. If your insurance does not cover the estimated amount, you will be responsible for the remaining balance.
- Our office **does not guarantee** that your insurance will pay. If a claim is unpaid after **60 days**, you may be billed directly. Any balance **not paid within 90 days** may be turned over to collections.
- Our office **will not** enter disputes with insurance companies regarding claim denials. Filing claims is a **courtesy** we provide, but it is ultimately **the patient's responsibility** to know and understand their insurance benefits. If a claim is denied, we will notify you and provide any necessary documentation for you to dispute the claim directly with your insurer.

Insurance Documentation

- If your insurance company requires a specific form to be completed, you must bring it to each appointment. Without the required documentation, we **cannot** file claims, and you will be responsible for payment in full at the time of service.
- Some plans require correspondence from the patient or policy holder directly, such as information regarding additional insurance coverage or student status. It is the patient's responsibility to handle these matters directly with their insurance provider. Should a claim go unpaid for more than 30 days because of this, the claim will be closed, and the patient will be billed directly for all services at the full-service fee.
- **Verification of benefits is required.** If we are unable to verify your insurance benefits, you will be responsible for full payment at the time services are provided. We ask for a minimum of 2 business days to verify new insurance coverage to ensure a full verification can be completed.

We appreciate your cooperation and look forward to providing you with exceptional dental care. If you have any questions, please contact our office.

* Accounts not paid in full after 90 days from the time services are rendered may be referred to collections or pursued legally in the courts.

Signature: _____ Date ____/____/_____

GENERAL CONSENT FOR TREATMENT

I _____ (patient first and last name), agree to treatment provided by David Langer DMD

This includes the following, but is not limited to:

- Examinations
- X-Rays/Radiographs
- Treatment recommendations
- Extraoral examinations
- Intraoral examinations

Signature: _____ Date ____/____/_____

HIPAA- AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name _____ D.O.B. ____ / ____ / ____

Authorization for release of Protected Health Information to family members, significant others, and/or friends.

I authorize the release of all health information including diagnosis, dental records, digital x-rays rendered, and the release of financial and/or insurance claims information. This authorization for the release of information will remain in effect until terminated in writing.

This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

(_____) Information may only be released to me.

Authorization for release of Protected Health Information to Dental/Medical Professionals for treatment, payment and healthcare operations

I authorize the release of my Protected Health Information as necessary for treatment, payment and healthcare operations by electronic transmission, including e-mail, facsimile and by U.S. Mail. It is the policy of David Langer DMD to protect the electronic transmission of PHI as well as to fulfill our duty to protect the confidentiality and integrity of our patient's PHI as required by law, professional ethics, and accreditation requirements. The information released will be limited to the minimum necessary to meet the requestor's needs.

Acknowledgement of receipt of Notice of Privacy Practices

I have read and/or been given a copy of David Langer DMD Notice of Privacy Practices, which describes how my health information is used and shared. I understand that David Langer DMD has the right to change this notice at any time. I understand that I may obtain a current copy by asking David Langer DMD. My signature below acknowledges that I have read and/or been provided with a copy of the Notice of Privacy Practices.

Print (Patient/Parent/Guardian) Name: _____

Signature: _____ Date ____ / ____ / ____

PHOTO CONSENT

I, _____ (please print full name), grant permission to David Langer DMD and its employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me or members of my family, for the publication, promotion, or advertising, in any manner or in any medium. I hereby release David Langer DMD and its legal representatives for all claims and liability relating to said videos or images.

OR

_____ I DO NOT give permission.

If legal guardian of patient(s), please list the name(s) here:

Name(s): _____

Signature: _____ Date ____ / ____ / ____