



John F. Rooney, DDS • Rebecca A. Neill, DDS

Office Policy

Thank you for choosing us as your health care provider. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

Full Payment is due at the time of service.

We accept cash, personal checks and Visa, MasterCard, American Express, Discover.

We offer Care Credit.

Regarding Insurance

As a service to our patients we will be happy to submit an insurance claim and any additional information required from your insurance carrier to assist you in receiving your maximum insurance benefit. However, in the event of unpaid benefit by your insurance company, you will be responsible for the balance in full. Your insurance is a policy contract between you and your insurance company; we are not a party to that contract. If you have a question about why your insurance has paid a certain amount or disallowed the amount, we encourage you to call your insurance. **If your insurance has not paid your account in full within 45 days the balance is due in full.** All co-pays and deductibles are due at the time of service. Some procedures may not be covered by your insurance, therefore you may choose to verify with your insurance before treatment is started. If you are covered by more than one dental insurance company, please do not assume that you are covered 100%. Some insurance companies do not coordinate benefits and/or have waiting periods on some procedures. It is your responsibility to verify this information. Please provide our office with all employment insurance information when you arrive for your appointment so we can properly submit your claims.

Usual and Customary Rates

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor (or guardian of the minor) is responsible for full payment.

Missed Appointments

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$50.00. Please help us serve you better by keeping schedule appointments.

Please let us know if you have questions or concerns. I have read the Office Policy. I understand and agree to this Office Policy.

Signature _____

Date _____

Family Dentistry

530.222.0920 • fax 530.222.0921 • 1425 Victor Avenue, Ste A • Redding, California 96003

NOTICED OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet
I, _____, acknowledge I have received a copy of the Dental
Materials Fact Sheet dated October 2001 from John F Rooney, D.D.S.

Patient Signature

Date

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices form time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I Understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date:

Initials:

Reason:

Patient Information

Date _____

Patient's Last Name: Last _____ First _____ Middle Int. _____
Preferred Name _____ Social Security# _____ Driver's Lic. # _____
Address: Street _____ City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____ Cell Phone () _____
Birthdate _____ Age _____ Marital Status _____
Employer _____ Occupation _____ # Years Employed _____
Spouse's Name _____ First _____ MI _____
Employer _____ Occupation _____ # Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name: Last _____ First _____ MI _____
Mailing Address : Street _____ City _____ State _____ Zip _____
Home Phone _____ Employer _____ Work Phone _____
Social Security # _____ Birthdate _____ Relationship to Patient _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Birthdate _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes () No () If yes:
Insured's Name _____ Insured's Soc. Sec. # _____ Birthdate _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____ Phone _____

All dental services performed without prior financial arrangements must be paid at the time of service. Insurance plans are the responsibility of the insured; billing insurance is a courtesy to our patients. I hereby authorize my insurance to pay directly to my dentist. A service charge of 1/12 per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 60 days. If payment is not received promptly, I agree to pay back any fees charged to me in the collection process. I have read the above conditions of treatment and agree to their content.

Signed _____ Date _____

