T.J. Schoen Family Dentistry: 257 Main St. W., P.O. Box 128, Wabasha, MN 55981
Phone: 651-565-4647 Fax: 651-565-2899 Website: www.schoendentistry.com

PLEASE PRINT

Patient Name: ______________________________________ SS#______________________DOB______________

Guarantor:____ SS#______________________DOB______________

The Guarantor is the person financially responsible for the patient account.

Address: ____ Driver License #____________________________

All Phone #'s (H) _______________________ (W) ___________________________ (C) ________________________

EMAIL____ Texting (YES) or (NO)

In case of emergency, nearest relative *not living with you*.

Name __________________________________ Relationship ____________________ Phone # _________________

Thank you for choosing us as your dental health care provider. If you have any questions about this or any other office policy or procedure, we will be pleased to discuss them with you.

Missed Appointments

We request a 48-hour notice to cancel your appointment unless it is a true emergency. *If you fail to show for your appointment, we reserve the right to charge a missed appointment fee or dismiss you from our practice*. We have reserved staff and facilities to provide services to you whether you are here or not. Please help us serve you and our other patients better by keeping scheduled appointments.

Payment Options

We bill most dental insurance plans directly but you are responsible for costs not covered by your plan. **Payment arrangements shall be made before restorative treatment begins.** If you are uncertain about your treatment, ask to see your treatment plan. We accept cash, checks with proper identification, Visa/MC and CareCredit. We charge a $25.00 fee for all returned checks. We offer a courtesy discount to uninsured patients paying in full on the date of treatment: *Cash/Check 5%; Credit Card 3%*; *Senior (65+ paying same day) additional 5%.*

We offer extended payment plans through CareCredit**.** Ask us for a brochure. Our business office will be happy to discuss this option with you.

A charge of 18% APR will be added to all accounts past 60 days. Any accounts not paid in full within 60 days may be sent on to professional collection services.

Dental Insurance- Please provide your ID card so we may scan it into your chart.

Subscriber Name ______________________________ DOB_____________________ SS# ________________________

Employer ____________________________________Group# ___________________ID# _________________________

Employer City and State _______________________ Patient Relationship to Subscriber _________________________

Our office will submit dental insurance forms to your insurance carrier. It is your responsibility to provide us with accurate insurance information and notify us of changes right away. Each insurance plan is unique so it is very important for you to become familiar with your individual policy. We understand that families are defined in many different ways. For accounting purposes, whoever signs the financial agreement with TJ Schoen Family Dentistry is the responsible party for payment. It is your responsibility to collect from any other parties who may also share legal financial responsibility.

CONSENT SIGNATURE

Insurance consent: "I ask for and agree to have insurance benefits paid to this facility. My dental provider may release to my insurance company any information regarding my dental history, symptoms, treatment, and examination results and diagnosis."

Guarantee of account: "I understand that my dental insurance may pay less than the actual bill for services. I agree to pay for services not covered by a third-party payer. I understand that if dental insurance benefits are not payable to this office, I am required to pay for services in full at the time I receive them."

"Procedures involving medical insurance will require payment on day of service."

"I am financially responsible for payment for all patients listed on my account. If credit is extended for any reason I authorize TJ Schoen Family Dentistry to obtain my credit report."

You agree that in order for us to service your account or to collect any amounts you may owe, we and our agents and affiliates may contact you by telephone at any telephone number associated with your account or any of your telephone numbers we may discover, including wireless numbers, and that such contacts could result in charges to you. You agree that methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system as applicable, emails, text messages and facsimiles.

Consent for treatment: "I authorize the dentist and his staff to perform preventive and diagnostic procedures & treatment as may be necessary for proper dental care. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services rendered."

Date: ______________________________________

Signature: __________________________________

Print: ______________________________________

This is a legal and binding agreement with your signature. It is understood that this executed copy of the Financial Policy shall cover dependents who are also patients of this practice. The paper copy will be scanned and then it is yours to keep.

List other household members who are patients:

Name Date of Birth

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement *

A copy of HIPAA privacy practices was presented to me. Your signature below is a receipt for the whole family.

Signature:___________________________________

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□Individual refused to sign
□Communications barriers prohibited obtaining the acknowledgement
□An emergency situation prevented us from obtaining acknowledgement
□Other (Please Specify)