El Dorado Hills Cosmetic, Implant & Family Dentistry

www.DrJonahTabrizi.com info@DrJonahTabrizi.com
993 Governor Dr., Suite 104 • El Dorado Hills, CA 95762 (916)941-1515

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Emergency Contact (Name & Phone Number)

_____

_____

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Occupation _____

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Plan Phone Number _____

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Insurance Plan Phone Number _____

Office Policy

Missed Appointments: Unless cancelled at least 2 business days in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. Be advised that treatment plans that are $2000.00 or less, if cancelled in less than 2 business days, may receive a 10% charge of the full treatment price. $2000.00 and more, will receive a 20% charge. There is also a 30% charge for no show appointments.

Late Policy: We strive to be on time so as a courtesy let us know in advance if you are going to be late. All patients that are 15 minutes late will be rescheduled unless authorized by staff.

Payment agreement: All professional services rendered are charged to the patient and are due at the time of service. Full payment is due at time of service. We accept Cash, Checks, Visa, Mastercard, American Express, and Care Credit. We may accept assignment of insurance benefits for some patients. Necessary forms will be completed to file for insurance carrier payments. However, we require your estimated co-payment to be paid at time of service. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. WE ARE NOT A PARTY TO THAT CONTRACT. If your insurance company has not paid your account in full within 60 days the balance will be automatically billed to you and due immediately.

All returned checks will be subject to a returned check fee. Any account balances that remain unpaid for 60 days from the date of service shall accrue interest at a rate of 1.5 percent (18%) per annum and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for any and all collection costs. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and attorney's fees incurred.

Emergency Cases: In case of emergency during your visit we will dial 911 for assistance. In this case if Ambulance has to escort you to the hospital, you are responsible for the cost of all transportation and emergency visit payments.
Important: If there is a possibility that you are pregnant, please tell us before x-rays are taken.

Please notify receptionist of any changes to your address, phone number, e-mail, or insurance coverage.

The highest compliment our patients can give is the referral of their friends or family. Thank you for your trust and have a great visit.

PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR CONCERNS. I HAVE READ THE OFFICE POLICY AND I UNDERSTAND AND AGREE TO BE RESPONSIBLE FOR ALL CHARGES.

Signature _____ **Date** _____

Assignment Of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. This does not eliminate your financial obligation for your treatment.

We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedure upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise.

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to the doctor for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

I further consent to be contacted by the dentist, or any agent of the dental office, any collection agency (or agent thereof), or attorney to whom an unpaid balance has been assigned or referred. I consent to be contacted by mail at any address that I provide to the dental office and/or facsimile, email, or phone number that I provide to the dental office or any agent of the dental office.

Authorization to Release Information

I hereby authorize the release of any information necessary to insurance carriers regarding my treatments, process insurance claims generated in the course of examination or treatment, and allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

On behalf of myself and/or my dependents, I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I affirm that any payments made to me by my insurance carrier will be immediately transferred to the doctor.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR,

Signature _____ **Date** _____

I have read and understand the Dental Materials Fact Sheet
(available to read at the office of Dr. Jonah Tabrizi, DDS)

Signature _____ **Date** _____

Patient - Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration as provided by California Law, and not by a lawsuit, or resort to court process, except as California law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:

The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn) and heirs, assignees or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership and any employes, agents, successors in interest, heirs and assignees of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understands and agrees that any dispute of the sort described in Articl I between doctor and patient will be subject to compulsory, blinding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable):

Patient understands and agrees that if doctor treats her during pregnancy, any dispute or sort described in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, blinding arbitration.

Article III.

A. Informal Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient wil promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection fo the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant to California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:

If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notie within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

Patient

Signature _____ **Date** _____

Final signature encompasses all signatures necessary for this document.

Response Date: _____