# WELCOME

## PATIENT INFORMATION (CONFIDENTIAL)

Date _____

Name _____ Birth date _____ Soc. Sec.# _____
last first mi.

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Cell Phone (____) _____

Circle appropriate status: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone (____)_____

Spouse or Parent's Name _____ Birth date_____ Soc. Sec.# _____

Occupation: _____ If college student full-time or part-time Name of college _____

In case of emergency please contact _____ Phone (____) _____

Whom may we thank for referring you? _____

## ACCOUNT INFORMATION:

## PRIMARY DENTAL INSURANCE INFORMATION (please present your insurance card)

Name of insured _____ Soc.Sec.#_____ Relationship to patient _____
Employer's name _____
Insurance Company _____ group# _____ ID# _____
Address _____ City _____ State _____Zip _____

## SECONDARY DENTAL INSURANCE INFORMATION (please present your insurance card)

Name of insured _____ Soc.Sec.#_____ Relationship to patient _____
Employer's name _____
Insurance Company _____ group# _____ ID# _____
Address _____ City _____ State _____Zip _____

## PERSON RESPONSIBLE FOR ACCOUNT (CIRCLE) Patient Father(husband) Mother(wife) Guardian

Payment is due upon completion of services: we accept cash, check and all major credit cards.

****SERVICE CHARGE ****

If I do not pay the entire new balance within 60 days of the service date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney' fees incurred.

**For our patients with dental insurance:** We are happy to assist you in filling out the necessary forms to help you receive the full benefits of your coverage. The relationship constitutes an agreement between the **carrier** and the **patient. As such, we can make no guarantee of estimated coverage or payment. All charges incurred for dentistry not paid by the insurance company for services rendered is the responsibility of the patient.**

## AUTHORIZATION

I hereby authorize payments directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X_____ Date _____

# Financial Agreement

We at Dr. Campanino and Dr. Ilacqua's office thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance proof of insurance, or participate in a plan that will honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, Care Credit, and in-state checks). A $35 service fee will be charged for all returned checks.

**Interest**
Interest will incur if a balance remains unpaid after 60 days.

**Insurance**
Please remember that our insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is in-network or out-of-network with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect estimated co-payments, co-insurance and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, the guarantor (patient holding the insurance coverage) is responsible for all out-of-network fees. If we have not contracted with your carrier we will not negotiate reduced fees with your carrier.

**Missed Appointments:**
We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee will apply. These fees are typically $50.

**Medical Records Fee:**
Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patients' rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of files, and or summaries.

**Timeliness of Appointments:**
We try to see everyone in a timely manner but if we are taking too long, please let our scheduling coordinator know so we can best serve your needs.

We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require assistance from anyone in our business.

I have read and understand the above financial policy. I agree to assign insurance benefits to Vincent S. Campanino DDS PC whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collection if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____