PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of your practice**

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*,which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this____ day of ___________, 20___.

Print Patient Name: ______________________________

Relationship to Patient: ___________________________

Signature: _____________________________________

GRADY A.GIBSON DMD
FAMILY DENTISTRY

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DATE:____________________

PATIENT: ____

Last First Middle

MARITAL STATUS: MARRIED ________ SINGLE ________ WIDOWED _______

PATIENT ADDRESS: ____

PATIENT HOME PHONE #: ______________________ CELL PHONE #: ________________________

PATIENT SS#: ____________________________ EMAIL ADDRESS: ________________________

PERSON RESPONSIBLE FOR PAYING ACCOUNT: ____

ADDRESS AND PHONE NUMBER OF THAT PERSON IF DIFFERENT FROM ABOVE: ________________________

____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? NAME AND PHONE #: ________________________

DENTAL INSURANCE COMPANY: ____

NAME OF INSURED: ______________________________ **DATE OF BIRTH:** ________________

SS# OF INSURED: ________________ **INSURED PLACE OF EMPLOYMENT:** ____________________

PATIENT INFORMATION SPOUSE INFORMATION

____________________________ FIRM ________________________________

__________________________ BUS. ADDRESS ______________________________

__________________________ CITY/ZIP CODE ______________________________

__________________________ BUS. PHONE ________________________________

_________________________ PRESENT POSITION _____________________________

REFERRED BY: ____

LAST DENTAL VISIT: ____

PURPOSE OF THIS VISIT: ____

I agree to pay for all professional fees and treatment at the time of service, or my portion not Covered by dental insurance, for myself, or above named patient, unless other financial Arrangements are approved. I also agree to pay for all costs of collection, including attorney fees, and court costs, should additional means of collection be required. In addition, my Signature on this form is my acknowledged authorization for the Dr. to seek a Credit Report if Credit is extended.

SIGNATURE: ____________________________________ Date: ________________________

HEALTH HISTORY UPDATE

Date of Birth________________ Do you have excessive bleeding from cuts ______________

Physician ____________________________ Last Physical exam ____________________

Physicians care now? _____________ Reason _____________________________________

(Women) Are you pregnant? __________ Expecting when? _______________________

Are you taking any Drugs, Medication or pills now? __________

If yes, what ____

Have you ever had an allergic or adverse response from any drugs ? ______________________

What? ____

Comments: ____

HAVE YOU A HISTORY OF	YES	NO
Abnormal Blood Pressure	___	___
Heart Disease	___	___
TB	___	___
Anemia	___	___
Arthritis	___	___
Rheumatic Fever	___	___
Radiation Treatment	___	___
Diabetes	___	___
Hepatitis	___	___
Heart Murmur	___	___
Aids	___	___
Any Artificial Joint Prosthesis or Heart Valves	___	___
Are you now or have you ever received treatment For Alcohol or Drug Abuse	___	___
Have you had Skin Grafts	___	___

Dates/When ______________________

Signature of Patient or Adult ____

Dr. Grady Gibson DMD and Staff have my permission to contact me regarding my appointments and other dental information pertaining to me by text and/or email:

Signature:____________________________ Cell Phone #____________________________

Date: _____________________ Email: _________________________________

Dr. Grady A. Gibson , DMD Phone # (859)581-1400 Fax# (859)581-0126

FINANCIAL OPTIONS AND PAYMENT ARRANGEMENTS

PATIENT NAME ____________________________ DOB _________________ DATE___________

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and your payment options. At the onset of treatment, we will provide you with an estimate of the total fees expected. Please understand that this will only be an estimate. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the word *estimate* as dental benefits are determined by each patient's dental contract. Every patient's dental plan is different, and necessary dental services are not necessarily covered. Most dental plans are designed to assist patients with their dental expenses. Very few dental plans fully cover all dental services. If you bring a copy of your dental plan, our staff will be happy to help you interpret your dental benefits. Without a copy of your dental benefits plan, only an estimate can be provided based on what a "typical" dental plan provides. If your dental plan pays more than expected, and you have paid your expected portion, you will receive a prompt refund. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determined that you were not eligible for coverage, the balance becomes your responsibility.

Thank you for reviewing your payment options and indicating your choice of payment. We appreciate the confidence that you have placed in us caring for you and your family. We are available at any time to assist you with your account. Please feel free to contact us with any questions you have regarding the payment options listed below.

PAYMENT OPTIONS

____ **PLAN A: Payment as Services are Rendered**

You may use cash, check, credit or debit card to make payment at the time of service.

____ **PLAN B: Monthly Payment Plans**

For our patients who want to make monthly payments, we offer short and long term financing through Care Credit. A business staff member will gladly assist you with the application process.

____ **PLAN C: Insurance Coverage**

Our goal is to help you maximize your dental benefits. As a courtesy to our patients, we are happy to bill dental plans for dental services. Please remember that the benefits available under the terms of your dental contract have been determined by your employer and your insurance carrier. We do not have access to accurate benefit information unless you provide a copy of your dental benefit booklet. If you do not have a copy of your dental benefit plan, we can only estimate benefits based upon other patients' experiences. Your estimated portion is due in full the day of treatment.

Please check Plan A, B or C to indicate how you would like to pay your portion.

I, ________________________ have chosen Plan (s) ______ above and accept full responsibility for this account. I understand that any insurance estimate given by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am responsible for all charges incurred for dentistry performed upon me and my dependents. Any insurance claim not paid in full after 60 days will become my responsibility at that time.

Responsible Party Signature ________________________________ **Date**________________