Bluegrass Oral Surgery & Dental Implant Center
OFFICE FINANCIAL POLICY

Patient Name: _____
Date: _____

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license), and credit cards. There is a $45 returned check fee due and payable from you for each check payment returned to us by your bank.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

MANAGED CARE PARTICIPANTS: Some benefit plans require pre-authorization and specialist referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary prior to your visit. All co-payments or patient out-of-pocket fees are due and payable at the time of service.

MEDICARE PATIENTS: We do not participate with Medicare.

MEDICAID/WELFARE PATIENTS: All patients must provide current necessary eligibility identification form prior to being seen.

SURGERY FEES: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Your insurance carrier may require prior authorization.

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. To assist our patients, we offer financial arrangements and/or alternative financing sources. Please ask our billing personnel for additional information.

WORKERS COMPENSATION: If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

PERSONAL INJURY CASES: This office does not accept liens nor bill for auto-accident or other liability or lawsuit-related cases. The patient is responsible for services provided at the time of service.

FOLLOW-UP VISITS: Post-operative office visits may or may not be necessary. If you need to come back there is no additional charge. IMPLANT PATIENTS: You will have an $80 charge for your yearly follow-up x-ray.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least 24 hours' notice when canceling an appointment. The practice reserves the right to dismiss patients with excessive cancelled appointments.

Please check one: I have paid my insurance deductible for the current year ☐ Yes ☐ No ☐ Don't Know

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Romeo N. Laureano. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor /Patient's Signature _____ **Date** _____

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.

Guarantor / Patient's Signature _____ **Date** _____

Witness _____ **Date** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Bluegrass Oral Surgery & Dental Implant Center
Romeo N. Laureano, D.M.D., P.S.C.
120 W. Stephen Foster, Suite 107
Bardstown, KY 40004
(502) 348-1155

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* from 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 of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason:

To our patients

Due to the amount of missed appointments, we are setting forth a new policy for cancellations and no show appointments. For our office, a missed appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient deserves.

We are simply going to ask you to be faithful about keeping all future appointments. We understand that things happen, schedules do change, however, we ask that you provide us with a ***minimum of 24 hours notice*** *for any appointment changes. Per Dr. Laureano's discretion, two consecutive cancellations will result in dismissal from the practice. For any appointments that are missed without notification to our office, a $100.00 fee will be assessed. Future appointments will not be scheduled until the fee is* ***paid in full****. The payment for the missed appointment is the responsibility of the patient and* ***cannot be billed to any insurance carrier and is due upon receipt of the bill.***

We value you as a patient and look forward to seeing you for future appointments.

I have read and understand the statement noted above.

Please Print Your Name

_____

Patient/Guardian/Responsible Party

_____ *Date* _____

Witness

_____ *Date* _____

09/25/2014

Bluegrass Oral Surgery

Patient Authorization or Use and Disclosure of Protected Health Information

By signing, I hereby authorize Bluegrass Oral Surgery to use or disclose protected health information (Labs, X-rays, Reports, Treatment Plans) about me to only the following people:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

The authorization will expire on: Indefinitely or _____ (Date of Expiration).

- The practice will not receive payment from a third party for using or disclosing Personal Health Information (PHI).
- I may inspect or copy the PHI to be used or disclosed.
- When my information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the right to refuse to sign this authorization.
- I do not have to sign this authorization in order to receive treatment from Bluegrass Oral Surgery. I have the right to refuse to sign this authorization.
- I have the right to revoke this authorization by submitted a written request to this office.

I wish to be contacted in the following manger (check all that apply):

Home telephone: _____

- ☐ O.K. to leave a detailed message
- ☐ Just leave a call back number

Cell Phone Number: _____

- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

Written Communication:

- ☐ O.K. to mail medical information to my home address

Work Phone Number:

- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

****If this information should change, it is your responsibility as our patient to notify us of the changes.***

Printed Name: _____ Date/Time:_____

Patient Signature:_____ Date/Time:_____

Bluegrass Oral Surgery & Dental Implant Center
NEW PATIENTS' INFORMATION SHEET

PATIENT INFORMATION

Patient's Full Name *(First, M.I., Last):*

Date of Birth: Age: Sex: M / F Marital Status: S M W D

Mailing Address:

Home #: Cell #: Work #:

Social Security #: Driver's License #:

Employer: If Student, School Name:

Name of Pharmacy: Phone #:

Referring Dentist or Physician:

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: Relationship to Patient:

Date of Birth: Social Security #: Driver's License #:

Address:

Home #: Cell #: Work #:

Employer:

Emergency Contact: Home #: Work #:

INSURANCE INFORMATION

Insurance Co.: Phone #:

Group #: Policy ID #:

Insured's Name: Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: Phone #:

Insured's Social Security #: Date of Birth: Sex: Male / Female

I hereby assign, transfer, and set over to Romeo N. Laureano, DMD all of my rights, title, and interest to medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature Date

Front & Back

HEALTH HISTORY

Patient's Name _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe ..... Y N

_____

_____

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping a jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofin? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Osteoperosis Medications ..... Y N
   - F. Steroids (Cortisone, etc.?) ..... Y N
   - G. Tranquilizers? ..... Y N
   - H. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - I. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.) ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

_____

_____

10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctors Initials _____

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions

Date	Exceptions or changes	Patient's Signature	Doctor's Initials