

Generation Dental Group

Responsible Party & Insurance Information

(If other than patient)

Name: _____ Male Female Married Single Other _____

Social Security #: _____ Birth Date: _____

Phone: Home _____ Work _____ Ext: _____ Cell: _____

Address: _____
Street Apartment # City State Zip Code

Primary Insurance Information

Employer Name & Address: _____

Insurance Plan Name: _____ Group #: _____

Phone Number: _____ Patient's relationship to insured: Self Spouse Child Other

Consent for Services

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing, unless previous financial arrangements have been made.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid at the time the services are performed. If I carry insurance, I understand that this office will help prepare my **PRIMARY** insurance forms to assist in making collections from that insurance carrier and will credit such collections to my account.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. Since it is not possible to coordinate insurance payments from any **SECONDARY INSURANCE CARRIER**, we are unable to accept payment from your secondary insurance. We will be happy to assist you when you file for your reimbursement from that carrier.

A billing charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) or \$15.00 minimum per month will be charged on the unpaid principal balance (including insurance payments due) on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

I agree to the above stated conditions and I hereby authorize treatment and direct payment of the dental benefits otherwise payable to me, directly to Dr. Julie L. Ring.

X _____ Date: _____
Signature of Patient / Responsible Party / Parent or Guardian

Cancellation Policy

I understand that a minimum of \$25.00 will be charged to my account for any appointment cancelled or rescheduled within a 24 hours of my original scheduled appointment time. Any appointment in which I do not arrive for and no notice was given to Dr. Ring there will be a \$25.00 (minimum) fee charged to my account. These fees must be paid before any additional appointment can be scheduled. If there are 3 or more appointments cancelled or broken within a 1 year period Dr. Ring holds the right to no longer see me as a patient.

X _____ Date: _____
Signature of Patient / Responsible Party / Parent or Guardian

HIPAA Consent For Use And Disclosure Of Health Information

Purpose of consent: By signing this form, you will consent to your use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information and of completely before signing this consent. You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

X _____ Date: _____
Signature of Patient/ Responsible Party/ Parent or Guardian