For your convenience, our patient forms have ACTIVE FIELDS you can fill out on your computer to then print. Click on the fields to enter your information.

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

Dental Solutions Of Avon/Indy

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL SOLUTIONS

SITARAM CENTER
For Implants & Oral Surgery

AVON OFFICE:
105 S. Raceway Rd., Ste. 140
Indianapolis, IN 46231
317-273-ZOOM (9666)
www.IndyDentalSolutions.com

COLUMBUS OFFICE & ORAL SURGERY CENTER:
3780 Jonathan Moore Pike, Ste. 180
Columbus, IN 47201
812-342-ZOOM (9666)
www.ColumbusDentalSolutions.com

www.ColumbusOralSurgeryCenter.com

DENTAL HEALTH QUESTIONNAIRE

1. When was your last dental visit? _____
2. Approximately how often were your appointments with your last dentist? _____
3. Are you experiencing any dental problems? If so, are they (circle one): ◯ Mild ◯ Moderate ◯ Severe
4. How often do you brush your teeth? _____ Floss? _____ Water Jet Floss? _____
5. Do you have any loose teeth? Yes ◯ No ◯ Chipped teeth? Yes ◯ No ◯ Broken teeth? Yes ◯ No ◯
6. Are there any spaces between your teeth where food often gets stuck? Yes ◯ No ◯
7. Do you frequently get headaches or migraines? Yes ◯ No ◯
8. Do you have any jaw joint issues (such as popping) or pain? Yes ◯ No ◯
9. Do you clench and/or grind your teeth when you are awake or asleep? Yes ◯ No ◯
10. Do your teeth feel worn down? Yes ◯ No ◯
11. Do you snore at night or commonly have a hard time sleeping well? Yes ◯ No ◯
12. Do you have any sort of sleep apnea that you are aware of? Yes ◯ No ◯
13. Have you ever had periodontal (gum) treatment of any kind? Yes ◯ No ◯
14. Do your gums bleed when you brush your teeth? Yes ◯ No ◯ When you floss? Yes ◯ No ◯
15. Have you ever had orthodontic treatment such as braces or aligner therapy? Yes ◯ No ◯
16. Are you interested in short-term braces? Yes ◯ No ◯
17. Do you have wisdom teeth? Yes ◯ No ◯ If so, are they bothering you? Yes ◯ No ◯
18. Are you interested in dental implants to replace missing teeth? Yes ◯ No ◯
19. What level of dental treatment are you interested in (circle one): ◯ Emergency ◯ Long-term
20. How do you feel about your smile? What (if any) improvements would you like to see?

21. What are your goals with our office?

Dental Solutions of Avon

NOTICE OF PRIVACY PRACTICE

John P. Weida, D.D.S.
105 S. Raceway Road #140
Indianapolis, IN 46231
(317) 273-9666
(317) 273-0679
johnpweida@gmail.com
Contact: Christy Ewing

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, **[**we will] [we usually will not]] ask you for special written permission.

We will ask for special written permission in the following situations: _____

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

when a state or federal law mandates that certain health information be reported for a specific purpose;
for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors
to aid in burial; or to organizations that handle organ or tissue donations;
uses or disclosures for health-related research;

uses and disclosures to prevent a serious threat to health or safety;
uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:
ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your

health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Dental Solutions of Avon / Indy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature/Responsible Party

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

OCR NOTICE OF NONDISCRIMINATION

Source: HHS Office for Civil Rights

Dental Solutions of Avon
complies with applicable Federal civil rights laws and does not discriminate on the basis of
race, color, national origin, age, disability, or sex.

Dental Solutions of Avon
does not exclude people or treat them differently because of race, color, national origin, age,
disability, or sex.

Dental Solutions of Avon:

• Provides free aids and services to people with disabilities to communicate effectively with
us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact [*Name of Civil Rights Coordinator*]
If you believe that [*Name of covered entity*]
has failed to provide these services or discriminated in another way on the basis of race,
color, national origin, age, disability, or sex, you can file a grievance with:
Christy Ewing, Office Manager
105 S. Raceway Rd. #140
Indianapolis, In 46231-1415
317-273-9666
317-273-0679 Fax
dental.solutionsofavon@gmail.com
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [*Name and Title of Civil Rights Coordinator*] is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human
Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint
Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services,
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

_____ _____
Patient Signature Date

STANDARD CONSENT FOR DENTAL PROCEDURES

PLEASE READ THIS FORM CAREFULLY AND DISCUSS WITH DR. SITARAM AND/OR STAFF MEMBER ABOUT ANYTHING PERTAINING TO YOUR TREATMENT THAT YOU DO NOT UNDERSTAND. WE WILL BE HAPPY TO EXPLAIN ANYTHING TO YOUR PRIOR TO YOU SIGNING THIS FORM.

I, _____ hereby authorize Dental Solutions of Avon, and whomever he may designate as his assistants, to perform upon me the surgery/procedure(s) that have been explained to me. I have requested and I now authorize Dental Solutions of Avon to do whatever he deems advisable if any unforeseen condition arises in the course of this designated surgery/procedure(s) after having been advised of the risks, advantages and disadvantages, and the consequences of non-treatment. I consent to the surgery/procedure(s) after having been advised if any alternate plans of treatment available, known material risks, and the advantages and/or disadvantages of any alternative treatment.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drug that may be deemed necessary for dental treatment, and I understand that there is an element of risk inherent in the administration of any drug or anesthesia. This risk included adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medication or drugs. I have been informed, and I fully understand, that inherent in any type of surgery/procedure(s) there are certain unavoidable complications. The most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of other dental restorations. Less common complications can include infection, loss or numbness in mouth and lip tissues, jaw fractures, sinus exposure and fragment remaining in the jaw which might require extensive surgery for removal. I realize that in spite of the possible complications and risks, my contemplated surgery/procedure(s) is necessary and desired by me.

I am aware that the practice of dentistry is not an exact science and that unknown conditions found may change the treatment recommendations and the fee that has been discussed and agreed by me. I understand that I will be informed of any changes to my surgery/procedure(s) at the realized convenience; however, I consent to the necessary surgery/procedure(s) deemed necessary by Dr. Dipesh Sitaram and Dr John Weida to conservatively treat the condition found. I acknowledge that no guarantees have been made to me concerning the results of the surgery/procedure(s) being performed. I also consent to photographs being taken. I understand they will be used for illustration and for documentation of my treatment.

I have provided an accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any/all instructions during, and after my surgery/procedure(s) as it is explained to me and I agree to report any unanticipated reactions to Dr. Dipesh Sitaram as soon as possible. I have had the opportunity to ask questions about my surgery/procedure(s) and responsive explanations have been given to me prior to signing this form. I understand that additional appointments may be required. I understand that additional appointments may be required and I agree to the terms of the cancellation policy. I understand that I will be charged a $45 fee if I fail to inform the office at least 48 hours in advance of any reserved appointment that I may cancel.

I am knowledgeable, and I agree, to the fees associated with the treatment recommendations and I agree to be responsible for the full payment of the surgery/procedure(s) rendered. I understand that a 1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims. I understand that in addition to accrued interest charges to my outstanding balance, I will be required to pay a $40 fee each month for the billing/statement that is generated for the collections of my account. I understand that I am responsible for any fees/costs that may be incurred for the collections of my account (e.g. collection agency fees, courts and attorney fees).

_____

Patient Signature Date

If minor, signature of parent or guardian

Financial Menu

Thank you for choosing Dental Solutions of Avon (hereinafter referred to as "we" or "Practice") for your dental care. Our goal is to provide for you a pleasant and relaxing environment with the finest care possible. We will strive to educate you about your diagnosis and treatment alternatives as well as your financial options. This document is designed to help you understand our office procedures and financial policies.

Payment

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, debit cards, checks, and cash are accepted. We will provide a written Treatment Proposal that will detail your diagnosis, treatment alternatives, estimated insurance coverage (if applicable), and your estimated portion due to begin treatment. No procedure performed on the human body can be guaranteed, as such payment is due and fees non-refundable regardless of treatment outcome. Payment for services rendered is also required if you decide to abandon a course of treatment in favor of an alternative form of treatment. I agree and understand in the event I do not pay Practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the Small Claims Court or Superior Court of Marion County, Indiana and agree that Indiana law governs all matters arising out of this agreement.

Dental Insurance

As a courtesy to you we accept, and will file, most primary insurance plans that do not require a specific provider. Please provide us with your identification card. Dental insurance is not intended to be a "pay all" service but is intended to help reduce your "out of pocket" expenses. Please be prepared to pay your deductible and estimated co-payment in full as treatment is initiated. We do NOT accept assignment of benefits for secondary insurance. Therefore any balance remaining after your primary insurance has responded is due in full. As a courtesy of those with secondary insurance's, we will prepare a claim form and submit it on your behalf when you have paid your account in full.

Insurance Payment

As a courtesy to you, we will file your primary insurance claim and are willing to wait up to 45 days from the date of service for payment. If payment has not been made, we will contact your carrier and strive to resolve any reason for delay. If unable to immediately resolve the situation a statement will be sent to you for immediate payment by the responsible party. Thereafter we will gladly assist you in attempting to obtain direct reimbursement from your carrier. WE MUST EMPHASIZE that our relationship is with you and not your carrier. Our primary concern is for your well-being and we structure our care accordingly. Insurance companies determine benefit packages and payment rates ("usual and customary" or UCR) by the plan type that is purchased by the employer/insured party-not by the level of care provided by our office. All charges including interest, accrued from the date services are rendered, are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof.

Appointments
We value your busy schedule and strive to see patients at their appointed time; we ask you to extend the same courtesy. Whenever possible please provide a minimum of 48 hours advance notice when requesting a scheduling change so that we can arrange care for other patients experiencing urgent dental needs. Failure to give adequate notice will result in a $45 office fee charged to your account that must be paid prior to rescheduling.

Returned Check Fee
A fee of $35 will be charged for any returned check. The entire outstanding balance and returned check fee must be paid immediately upon notification from our practice.

Acknowledgement, Release, and Authority
I as the patient, or as the authorized guardian or responsible party for the patient named, consent to treatment as necessary or desirable, including but not limited to drugs, medicines, performance of clinical treatment, labs, imaging, or other studies that may be performed, ordered or used by Practice. I certify that I am here only for the medical and/or dental treatment requested and also certify that I am not representing any third party or other entity.

I authorize Practice to use or release any protected health information, as used in Health Insurance Portability and Accountability Act (HIPAA) and in the manner described in Notice of Privacy Practices, to third party payers or other health practitioners as reasonably necessary for my treatment proper or for reimbursement thereof, and further hold harmless Practice from any and all damages resulting from the reasonable use thereof. I also give my consent to be contacted regarding my dental health, treatment, and scheduling and account information by telephone, e-mail, postcard, newsletter, and /or letter.
I authorize and request my insurance company to pay the Practice any monies due me as reimbursement for services rendered by Practice. I understand my insurance carrier may pay less than the total fee for services rendered and unconditionally agree to be responsible for and to pay all charges incurred on my behalf or on behalf of those for which I am responsible. I permit a copy of this authorization to be used in place of the original.
I agree to pay treble damages if I cash any insurance or other check that represent reimbursement to Practice for services rendered and I fail to immediately tender the monies due to Practice. **I agree and understand** in the event I do not pay Practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the Small Claims Court or Superior Court of Marion County, Indiana and agree that Indiana law governs all matters arising out of this agreement.
I further understand a 1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims. I agree to pay Practice a minimum fee of $45 for any appointment I schedule and fail to arrive for or cancel with less than 48 hours notice. I certify that any information I have provided today is correct to the best of my knowledge. I also understand that it is my responsibility to inform Practice or any Responsible Party and, if the patient is a minor, I certify I am legal guardian.

I am knowledgeable, and I agree, to the fees associated with the treatment recommendations and I agree to be responsible for the full payment of the surgery/procedure(s) rendered. I understand that a **1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims.** I understand that in addition to accrued interest charges to my outstanding balance, I will be required to pay a $40 fee each month for the billing/statement that is generated for the collections of my account. I understand that I am responsible for any fees/costs that may be incurred for the collections of my account (e.g. collection agency fees, courts and attorney fees).

Patient Name: _____

Responsible Party: _____

Signed: _____ Date: _____