



Patient Information

Patient Name: Last First MI
Male Female Married Single Child Other
Social Security #: Birth Date:
Phone (Home): (Work): Ext: (Cell):
E-Mail Address:
Address: Street Apartment #
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- AIDS, Allergies, Anemia, Arthritis, Artificial Joints/Premed, Asthma, Blood Disease, Cancer Type, Codeine Allergy, Diabetes Type, Dizziness, Depression Disorders, Epilepsy, Excessive Bleeding, Fainting, Glaucoma, Head Injuries, Heart Disease, Heart Murmur/Premed, Hepatitis Type, High Blood Pressure, Jaundice, Joint Replacement/Premed, Kidney Disease, Latex Allergy, Liver Disease, Nervous Disorders, Nickel Allergy, NSAID Allergy, Pacemaker, Penicillin Allergy, Pregnant, Radiation Treatment, Respiratory Problems, Rheumatic Fever/Premed, Rheumatism, Sinus Problems, Stomach Problems, Stroke, Thyroid, Tuberculosis Type, Ulcers, Venereal Disease, Other

Please list all prescription medications, over-the-counter medications, or herbal supplements that you are currently taking.

Name of Physician: Phone: Fax:

Referral Information

Whom may we thank for referring you to our practice?

- Another Patient, Another Doctor, Insurance, Newspaper, Radio, Website/Internet

Name of source referring you to our practice:

HIPAA

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy practices, which contains information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation. Occasionally it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

## Assignment of Insurance Benefits, Payment Policy, and Payment Options

The policy of MCDental Care, PLLC is to be paid directly by your insurance company. By signing the Consent for Services, you authorize direct payment to MCDental Care, PLLC and assume responsibility of all non-covered services or provider charges that may exceed insurance payment.

Our payment policy is as follows:

- Initial**
- **Payment is required the day services are rendered.**
  - **Returned checks are subject to a \$36 NSF fee and may be subject to an additional collection fee.**
  - **Balances over 30 days may be subject to additional collection action.**
  - **All accounts not paid within 90 days will be sent to a collection agency.**

For your convenience, we offer several payment options. Please read the following information:

- **Cash or Check.**
- **Visa, MasterCard, or American Express.**
- **Interest-free or extended financing through CareCredit.**

Credit balances on your MCDental Care, PLLC account are subject to reimbursement. A check will be issued by MCDental Care, PLLC within thirty days of your request for a refund. However, processing/transaction fees will be deducted from any refund in which credit balances occur due to a personal overpayment by credit card, CareCredit.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% annum) on any unpaid balance will be charged to the patient on all accounts exceeding 30 days past due, unless written financial arrangements are satisfied.

- Initial** MCDental Care, PLLC can only estimate insurance payments and laboratory costs. All dental services not paid by insurance are charged directly to the patient. Any unpaid balance, as well as attorney fees, court costs, and collection costs incurred by collection and enforcement of a debt are the responsibility of the patient.

## Cancellation Policy

- Initial** MCDental Care, PLLC updated cancellation policy: After hours, please contact Dr. Dziurgot on her cell (586.823.0422) to reschedule. There will be a \$35 fee for any cancellation within 2 business days. If two appointments are cancelled or no showed within 2 business days notice within a 12 month period, MCDental Care, PLLC will place your name on a call list. Three appointments without 2 business days notice within a 12 month period will result in permanent dismissal from the practice.

## Patient Acknowledgement and Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I have had full opportunity to read and consider the contents of this form and your Notice of Privacy practices. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of dentist/hygienist

Date: \_\_\_\_\_