2654 Fourth Ave, San Diego, CA 92103
(619)234-7493
www.demkobrockettdental.com

Patient Policy

PAYMENT & DENTAL BENEFIT POLICY:

We accept all PPO plans as a non-contracted provider, or "out-of-network" provider. We are "in-network" with the following 2 PPO plans: Cigna PPO (NOT Cigna Advantage) and Aetna PPO.

Delta Dental and Blue Cross Blue Shield PPO plans send payment to the patient directly, rather than to our office. This means Delta and Blue Cross Blue Shield patients will pay our office for treatment in **FULL** on the date of service, and those patients should receive the eligible benefit reimbursement within 10 business days.

For all patients, as a condition of treatment by this office, financial arrangements must be made in advance. All dental services performed without previous financial arrangements must be paid for at the time services are performed. **Patients with dental insurance understand they are ultimately financially responsible for all dental services rendered regardless of insurance claim payment status.** The practice depends upon reimbursement from patients for the costs incurred in their care. The office submits insurance claims on behalf of the patient. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

CANCELLATION POLICY: I understand I will be charged $40 for no-showing to an appointment OR cancelling appointments with less than 48 hours notice. Arriving to an appointment over 20 minutes late disrupts other patients receiving dental services and is considered a no-show. If you find yourself ill on short notice and alert us prior to the appointment, we will reconsider the cancellation fee. Patients with a history of no-shows and cancellations may be required to pre-pay for treatment to secure an appointment.

MUTUAL RESPECT POLICY: As a professional dental services provider we will treat you with respect. We also expect our patients to respect our entire practice staff at all times. We do not tolerate verbal abuse, physical abuse, profanity, or sexual harassment, among others.

COMPREHENSIVE CARE: Our practice practices comprehensive dental care. We work together with our patients to prioritize patients' needed dental treatment based on what we believe is best for your overall oral health. Some complex conditions may not be treatable at this practice requiring patients to be referred to a specialist or emergency medical services provider.

- ❑ I have read the above conditions of treatment and payment and agree to their content.
- ❑ I grant my permission to you or your assignee, to telephone me to discuss this policy or my treatment.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to patient: _____

2654 Fourth Ave, San Diego, CA 92103
(619)234-7493
www.demkobrockettdental.com

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate for a comprehensive evaluation.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

-Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in my treatment.

-Obtain payment from third-party payers.

-Conduct normal health care operations such as quality assessments and accreditation.

-I understand that in the normal course of providing healthcare my PHI may be transmitted via electronic messaging including, but not limited to, FAX, email, and telephone messaging.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to patient: _____

2654 Fourth Ave, San Diego, CA 92103
(619)234-7493
www.demkobrockettdental.com

GENERAL PATIENT INFORMATION

Name: _____ Birth Date: _____/_____/_____
How do you wish to be addressed?: _____ Social Sec #: _____
Residence Address: _____ E-mail: _____
_____ Drivers Lic #: _____
Mobile or Primary Phone #: _____ Other phone: _____
Employer: _____ Occupation: _____
Business Address: _____ Bus. Phone: _____
_____
Marital Status: _____ Spouse's Name: _____
Person responsible for the account: _____
Emergency Contact & Phone Number: _____
How did you hear about our practice?: _____

DEPENDENT INFORMATION

Child/Dependent's name: _____ Birth Date: _____/_____/_____
Residence Address: _____ School Grade: _____
(if different from above): _____
Who is legally responsible?: _____ Primary Phone: _____
Relationship to dependent: _____

DENTAL INSURANCE INFORMATION

If you have specific questions about treatment fee portions covered by your dental benefit program, please ask us to perform a benefit pre-authorization/pre-determination check.

POLICY OWNER INFORMATION (primary carrier)

Policy owner name: _____ Policy owner SSN: _____
Patient relationship to policy owner: _____ Policy owner DOB: _____/_____/_____
Insurance company: _____ Insurance Phone #: _____
Subscriber ID #: _____ Group Number: _____
Policy owner's employer: _____

SECONDARY CARRIER POLICY INFO SUMMARY (if applicable)

_____
_____