NORTEY DENTAL

Patient Financial and Insurance Agreement

Welcome to our office. We are honored that you have chosen us as your dental health care provider.

Quality dental care is a financial investment. If you have insurance benefits, we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. Your contract insurance benefits exist between you and your insurance carrier.

Please remember that you are ultimately responsible for your account with our office.

1. We accept payment for services by cash, check, Care Credit, Mastercard®, Visa®, Discover®, and American Express ®.

2. If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.

3. If your insurance does not cover 100 percent of the charges, you may be billed any additional amount. You will receive an estimate of your liability prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office.

4. When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated copayment and deductible be paid at the time of service. We may require a deposit at the time of appointment for some services that cost more than **$200.** Our office will let you know of any required deposit in advance. We will file insurance claims and accept assignment of benefits. We ask that payment be made within 14 days of the statement. In the event of a credit, we will promptly issue a refund. If your insurance does not pay within 45 days, we ask that you make the payment in full and contact the insurance company regarding reimbursement to you.

5. If you do not authorize your insurance benefits to Nortey Dental or are over your insurance limit, payment in full is expected at that time of service unless arrangements have been made in writing prior to treatment.

6. In cases of extensive treatment for which full payment cannot be made at the initial appointment, a financial arrangement may be reached. Documentation of this arrangement should be signed by the patient and office staff.

7. Fees quoted will be accepted for **90** days. If clinical conditions warrant a different treatment, you will be notified of changes prior to the procedure.

8. Our office requires 24-hour notice for any canceled appointments. A fee of **$25** may be assessed for canceling an appointment without 24-hour notice. Multiple missed appointments may result in dismissal from the practice.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Patient Signature

Date

Nortey Dental
1332 Post Road
Wells, ME 04090

Patient Information:

Name _____
Last First M.I.

Date of Birth: _____ / _____ / _____
Month Day Year

Telephone _____ _____ _____ Ext _____
Home# Cell# Work#

Mailing Address _____
Street (Unit/Apt#) City State Zip

Email Address _____

Emergency Contact Person _____ / _____
Name phone number

Do you have Dental Insurance? _____ _____ → Please present insurance card to be copied.
No Yes

Subscriber Name and D.O.B: _____

Subscriber social security #: _____

Name of the Employer: _____

Subscriber ID: _____

Plan Name and Group ID: _____

Who can we thank for your referral? _____

Authorization:

I hereby authorize payment directly to Nortey Dental of insurance benefits otherwise payable to me/the subscriber. I understand that I am responsible for all costs of dental treatment. I hereby authorize Nortey Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Nortey Dental to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____ _____

Patient or Responsible Party Date

Please be sure to sign Acknowledgement of our Notice of Privacy Practices

Annual Health History Questionnaire

1. What is your reason for today's visit?_____
2. Are you allergic to any medications? _____
3. Please list your current medications:
   _____
   _____
   _____
   _____
   _____
4. Have you ever been told to take antibiotics prior to a dental visit? _____
5. Have you or an immediate family member had an adverse reaction to anesthesia?_____

6. Please circle current or previous conditions:
   - History of heart problems
   - Liver disease
   - Artificial joints or valves
   - High or Low blood pressure
   - Cancer
   - Radiation or use of bisphosphonates
   - Circumstantial anxiety (dental phobic)
   - STD's, AIDS, HIV
   - Thrush/ Candida
   - Epilepsy
   - History of drug or alcohol abuse
   - Sleep apnea
   - Difficulties breathing associated with COPD, Emphysema, Asthma
   - Autism/Sensory
   - Hepatitis A, B, or C
   - Rheumatic fever
   - Recent unexplained weight loss
   - Diabetes
   - Chemotherapy
   - Nervous problems
   - Headaches
   - Cold sores/ fever blisters
   - Fainting dizzy spells
   - Seizures
   - General allergies
   - Bleeding/clotting conditions
   - Vertigo

Please list any conditions we may have missed that you feel are pertinent for us to know regarding your health.

_____

_____

Preferred Pharmacy:_____

Printed patients name:_____

Signature:_____ Date:_____

NORTEY DENTAL, PLLC
NII NORTE LOKKO, DMD
1332 POST ROAD, SUITE 1-A
WELLS, MAINE 04090

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. This HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this content in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

NORTEY DENTAL, PLLC

NII NORTE LOKKO, DMD

1332 POST ROAD, SUITE 1-A

WELLS, MAINE 04090

Tel: (207) 646-5297
Fax: (207) 216-9308

RECORD RELEASE FORM

I, _____ D.O.B _____ hereby authorize
(*Print Patient's name*)

_____
(*Former Dentist's name*)

To provide **Nortey Dental**

copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records that pertain to me.

This consent is effective until such a date as I can cancel the consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed:_____
(*Patient*)

Signed: _____
(*Parent, legal guardian, or POA of the patient, if patient is unable to sign for him/herself*)

Date:_____

Please email records to: **info@norteydental.com**