Account Registration

PATIENT INFORMATION

Name:	Birth Date:	Social Security #:	
Street Address or PO Box:	City:	State:	Zip Code:

Sex: M F	Home Phone:	Cell Phone:	Work Phone:

Emergency Contact Name and Phone:	Email address:

IF PATIENT IS MINOR-RESPONSIBLE PARENT OR GUARDIAN

Name:	Birth Date:	Social Security #:	
Address:	City:	State:	Zip Code:

Sex: M F	Home Phone:	Cell Phone:

PRIMARY DENTAL INSURANCE:

Subcriber Name:	Birth Date:	Social Security #:	Relationship to Patient:
Street Address or PO Box:	City:	State:	Zip Code:

Sex: M F	Home Phone:	Cell Phone:

Employer:		Insurance Company:
Group #:	Identification #:	Insurance Company Phone :

SECONDARY DENTAL INSURANCE:

Subcriber Name:	Birth Date:	Social Security#:	Relationship to Patient:
Street Address or PO Box:	City:	State:	Zip Code:

Sex: M F	Home Phone:	Cell Phone:

Employer:		Insurance Company:
Group #:	Identification #:	Insurance Company Phone:

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

Responsible Party Signature:____ Date:________________

Ladd Dental Group
Financial Policy

Payments: Payments are due at the time of service unless other arrangements have been made. This includes insurance co-pays, deductibles and treatment not covered by your insurance benefits.
Insurance: Insurance is a contract between you and your insurance company. We will bill your primary and secondary insurance as a courtesy to you. Although we estimate what your insurance company will pay, it is the insurance company that makes the final determination of the amount they will pay. You agree to pay any portion of the charges not covered or paid by insurance. Delays in payment from insurance company of more than 45 days will result with patient being billed the full amount.
Monthly Statement: If you have a balance on your account, we will send you a monthly statement. Payment is expected on receipt of the statement.
Finance Charge: A finance charge of 1.5% per month (18% per year) will be added to the account for all amounts overdue more than 30 days. The minimum finance charge will be $5.00.
Returned Checks: There is a fee (currently $25) for any checks returned by the bank.
Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If your account is submitted to a collection agency or to an attorney you agree to pay all reasonable collection and attorney fees. In case of suit you agree the venue will be in Howard County, Indiana.
Waiver of Confidentiality: You understand that if this account is submitted to a collection agency or to an attorney for litigation, the fact that you received specific treatment at our office may become a matter of public record. Your failure to timely pay constitutes a waiver of confidentiality.
Missed Appointment Fee: The second time a patient is late for an appointment, or cancels with less than 24-hours notice, a $20-$100 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients who miss three appointments will be dismissed from the practice.
Transferring of Records: If you want copies of your records and/or x-rays sent to another doctor or dental office, you must make this request in writing and our current copying fee must be paid before we will transfer your records. You authorize us to include all relevant information, including your payment history. If you are requesting your records be transferred from another doctor or dental office to us, you authorize us to receive all information sent.,
Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible to us for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect form the other parent.
Workers Compensation: If workers compensation is to pay for our services, we require a written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.
Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility and is due at the time of service. We cannot bill your attorney.

I HAVE READ AND UNDERSTAND ALL OF THE TERMS AND CONDITIONS OF THIS AGREEMENT.

Patient's Name ______________________ Parent or Guardian ______________________
(if patient is a minor)

Signature ______________________________________ Date ______________

Witness ____