SOULARD FAMILY DENTISTRY

PATIENT INFORMATION

DATE _____

NAME _____/_____/____ ☐MR. ☐MRS. ☐MS. ☐DR. ☐MALE ☐FEMALE _____
LAST FIRST M.I. BIRTHDATE

ADDRESS _____/_____/_____/_____ ____-____-____
STREET CITY STATE ZIP SOCIAL SECURITY #

PHONE _____ _____ _____ E-MAIL _____
CELL WORK ALTERNATE

EMPLOYER _____ _____
NAME ADDRESS

OCCUPATION _____

REFERRED BY _____ _____ MARITAL STATUS ☐SINGLE ☐SEPARATED ☐MARRIED ☐DIVORCED ☐WIDOWED

SPOUSE/PARENT INFORMATION

NAME _____/_____/____ ☐MR. ☐MRS. ☐MS. ☐DR. ☐MALE ☐FEMALE _____
LAST FIRST M.I. BIRTHDATE

ADDRESS _____/_____/_____/_____ ____-____-____
STREET CITY STATE ZIP SOCIAL SECURITY #

PHONE _____ _____ _____ E-MAIL _____
HOME WORK ALTERNATE

EMPLOYER _____ _____
NAME ADDRESS

OCCUPATION _____

PERSON RESPONSIBLE FOR ACCOUNT (IF SAME AS ABOVE, PUT "SAME")

NAME _____/_____/____ ☐MR. ☐MRS. ☐MS. ☐DR. ☐MALE ☐FEMALE _____
LAST FIRST M.I. BIRTHDATE

ADDRESS _____/_____/_____/_____ ____-____-____
STREET CITY STATE ZIP SOCIAL SECURITY #

PHONE _____ _____ _____ E-MAIL _____
HOME WORK ALTERNATE

EMPLOYER _____ _____
NAME ADDRESS

RELATIONSHIP TO PATIENT _____

IN CASE OF EMERGENCY (SPECIFY SOMEONE WHO DOESN'T LIVE IN YOUR HOUSEHOLD)

NAME_____ PHONE_____ RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

CARRIER _____ GROUP # _____ SUBSCRIBER'S NAME _____
ADDRESS_____ PHONE _____

CARRIER _____ GROUP # _____ SUBSCRIBER'S NAME _____
ADDRESS_____ PHONE _____

The above information is complete and accurate. It is my responsibility to update any changes in the above information. I understand that I am financially responsible for all charges whether or not paid by the insurance company.

SIGNATURE _____ DATE _____

ACCOUNT INFO
ACCOUNT NAME _____

ADDRESS _____

_____

TRUTH IN LENDING
EXPLANATION OF LATE CHARGES AND FINANCE CHARGES

LATE CHARGE: If your minimum payment is not received by the due date, you may be assessed a late payment charge. The amount of the late charge to be assessed is that maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be $5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $20.00, excluding Indiana which is $17.50, Minnesota which is 50¢ minimum or $5.00 maximum, and Montana which is zero. In IN, if the minimum payment is received within 10 days after the due date the late charge will be waived.

FINANCE CHARGE: A FINANCE CHARGE is imposed on those charges not paid in full within 30/60/90/120 days of the date you were first billed for the charges. The balance on which any **FINANCE CHARGE** is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement.

The **FINANCE CHARGE** is a periodic rate of 1.25% (1% in Washington - .58% in Michigan - .66% in Kentucky - .83% in Missouri) per month. (An **ANNUAL PERCENTAGE RATE** of 15% (- 12% in Washington - 7% in Michigan - 8% in Kentucky - 10% in Missouri)). The **FINANCE CHARGE** is computed by multiplying the balance on which the **FINANCE CHARGE** is computed by the periodic rate shown above. There is a $1.00 minimum **FINANCE CHARGE** (50¢ minimum in Minnesota and Indiana).

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights.

In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Soulard Family Dentistry
2229 South 12th Street
St. Louis, MO 63104

Dental Entity Name

_____ _____

Signature of Insured Date

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient | Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____