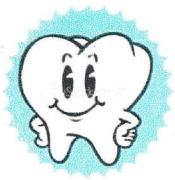

WELCOME

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely. If you have questions or need assistance, please let us know and we will be happy to help.

Patient Information

Name:_____ Date:_____
Soc. Sec #:_____ Birthdate:_____ Home Phone:_____ Cell Phone:_____
Address:_____ Apt #:_____ City:_____ State/Zip:_____
Check Appropriate Status: Minor____ Single_____ Married_____ Separated_____ Divorced_____ Widowed_____
If Student, Name of School/College:_____ City:_____ State/Zip_____
Patient's or Parent's Employer:_____ Work Phone:_____
Business Address:_____ City:_____ State/Zip:_____
Spouse/Parent's Name:_____ Employer:_____ Work Phone:_____
Whom May We Thank for Referring You?:_____
Emergency Contact:_____ Phone Number:_____
Patient E-Mail Address:_____

Responsible Party

Name of Person Responsible for this Account:_____ Relationship to Patient:_____
Address:_____ Home Phone:_____
Drivers License #:_____ Birthdate:_____ Financial Institution:_____
Employer:_____ Work Phone:_____ SS#:_____
Is This Person Currently A Patient In Our Office?: Yes:_____ No:_____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment.
Cash:_____ Personal Check: _____ Credit Card: _____ Care Credit: _____ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured:_____ Relationship to Patient:_____
Birthdate:_____ Social Security#:_____ Date Employed:_____
Employer Name:_____ Union or Local:_____ Work Phone:_____
Insurance Company:_____ Group #:_____ Policy/ID#_____
Ins. CO. Address:_____ City:_____ State/Zip:_____
How Much Is Your Deductible?:_____ How Much Have You Used?:_____ Max. Annual Benefit?:_____

Do You Have Additional Insurance?

Name of Insured:_____ Relationship to Patient:_____
Birthdate:_____ Social Security#:_____ Date Employed:_____
Employer Name:_____ Union or Local:_____ Work Phone:_____
Insurance Company:_____ Group #:_____ Policy/ID#_____
Ins. CO. Address:_____ City:_____ State/Zip:_____
How Much Is Your Deductible?:_____ How Much Have You Used?:_____ Max. Annual Benefit?:_____

Patient Medical History

Physician:_____ Office Phone:_____ Date of Last Exam:_____

	YES	NO
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain:_____		
Are you taking any medication(s) including non-prescription medicines?	☐	☐
If yes, what medication(s) are you taking?_____		
Have you ever taken Phen-Fen/Redux? (Diet Pills)	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐

Are you allergic to or have you had any reaction to the following:	YES	NO
Local anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics?	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg, nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other:_____		

Women Only	YES	NO
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Do you have or have you had the following?

High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina (Heart)	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problems	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other_____		

Patient Dental History

Name of Previous Dentist and Location:_____ Date of Last Exam:_____

Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following: problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement:_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent:_____ **Date:**_____

Accord Dental, Professional LLC
OFFICE POLICY
IMPORTANT! PLEASE READ ALL OF THIS INFORMATION!

We at Accord Dental want to take this opportunity to thank you for choosing our office for your dental care. Our practice continues to grow by referrals from our patients and your expression of confidence in referring your family and friends is greatly appreciated. We believe that you and your family can achieve an optimum state of dental health. This can only be accomplished through quality dental care and your personal commitment.

Office policy $: ***THE FEES FOR THE INITIAL APPOINTMENT ARE DUE ON THE DATE OF SERVICE.*** If future fee payments are difficult for you, please discuss other arrangements with the receptionist ***BEFORE BEGINNING TREATMENT***. Payment may be made by cash, check, money order, or credit card.

Insurance $: We accept indemnity, PPO, or, fee-for-service insurance plans. However, we *do not accept dental HMO* insurance plans. We send your claim to insurance and collect payment as best we can. ***It is your responsibility to know your insurance plan. There may be exclusions, waiting periods and other information that may effect payment by your plan.*** There are problems we can't resolve. At that point, ***we do not accept responsibility for filing your claim, collection from your company, or negotiating a disputed claim.*** We urge you to ask the staff any questions you may have. ***I certify*** *that* ***I have read and understand*** *the* ***terms*** of the above information. ***I understand*** *that my* ***dental insurance*** *carrier* ***may pay less*** *than the* ***actual bill*** *for services.* ***I agree to accept full responsibility for payment*** *of all services rendered* ***on my behalf or my dependents***.

Appointments $: ***As a courtesy to our patient's we request 2 business days notice*** if you must *reschedule an appointment.* We will remind you of your appointment and ***we do request a call back*** to verify your attendance. If you can't keep your appointment, the staff needs the most time possible to find someone who can arrange their working schedule to accommodate the opened treatment time. If we do not hear from you, we reserve the right to fill your appointment time with another patient and your appointment will be rescheduled. ***8:00, 9:00, 3:00, 4:00 and Saturday's are the most requested appointments.*** ***Should you have an appointment at these times and cancel, you may not be scheduled for these time slots again. Please put your appointments on your calendar. We do give you a reminder call as a courtesy but it is each patient's responsibility to be here at the appointment time.***

In return for your cooperation in these matters, we pledge to provide you with the very best dentistry we are capable of providing.

I certify that **I have read and understand** the **terms** of the above information. **I understand** that my **dental insurance** carrier **may pay less** than the **actual bill** for services. **I agree to the above financial policy** and **accept full responsibility for payment** of all services rendered **on my behalf or my dependents**. 1.5% interest fees will be charged on accounts with a balance remaining over 30 days. (18% APR) If collection procedures are necessary, the client will be liable for all collection fees, attorney fees, and court costs.

SIGNATURE:_____ DATE:_____

VERY IMPORTANT
PLEASE BE SURE TO READ THIS DOCUMENT!
DENTAL INSURANCE AND CLAIM INFORMATION.

Dental Insurance is a contract between you, your employer and your insurance carrier. Your dental insurance is not a contract between your insurance carrier and your doctor. If we are a **contracted provider** for your insurance, that means we have agreed to change our fees to reflect our agreement with that specific carrier's fee schedule.

Discount Dental Plans are not insurance. These plans allow you to purchase specific dental procedures for a discounted fee. Accord Dental discounts are given only if you pay your entire balance on the date your services are performed.

The reimbursement levels will vary from one insurance carrier to another. Your carrier may say they pay 80% for a procedure when, what they actually pay is 80% of the carrier's fee schedule. Insurance companies don't always pay what we are expecting because of specific rules they may have regarding specific dental procedures. We are happy to send a preauthorization request to the insurance company which gives you an idea of what your cost will be for any given procedure.

Filing insurance claims. Our office will file your dental insurance claims for you. You must provide us with accurate and complete insurance carrier information to properly obtain maximum reimbursement levels. Our office will trouble-shoot claims which have been delayed and/or contested by your insurance carrier. Because of the Federal Patient Privacy Act, there will be times when we will need your assistance in collecting from the insurance companies but we will do our best in getting the claims paid without your assistance. If we need your help we will give you a call.

Knowing your insurance. It is up to the patient/guardian which has the insurance policy to know your own insurance. For example, some insurance companies want 6 months plus one day in between cleanings, others don't care when you get your cleanings throughout the year. We are not able to let you know if your insurance will pay for your next cleaning. If you have questions as to whether or not your procedure will be paid, it is your responsibility to call the insurance company for verification.

Should you have questions, please ask a staff member and we will do our best to assist you within our limits of our expertise.

Agreement. I am aware that I am responsible for payment of this account as well as knowing my insurance policies and procedures.

Patient/Guardian_____ Date:_____

PATIENT **RIGHTS TO PRIVACY**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

Accord Dental, Professional LLC
2121 S. Oneida St. - Suite 321 - Denver, CO 80224

Written Financial Policy

Thank you for choosing Accord Dental, Professional LLC. Our Primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

Credit - Debit - Cash - Check - Care Credit - Lending Club

We offer a 10% courtesy discount to patients who pay for their treatment with cash prior to completion of care.

NO INTEREST payment plans from Care Credit and Lending Club if approved

Allow you to pay over time with NO INTEREST

Convenient, low monthly extended payment plans are also available

No annual fees or pre-payment penalties

Please Note:

Accord Dental, Professional LLC requires payment prior to the completion of your treatment unless otherwise agreement is made between the patient and the doctor. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. For larger, more comprehensive treatment plans of $400.00 or more, a $200.00 deposit is required to secure your initial treatment appointment, unless otherwise agreement is made between the patient and the doctor. For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. A fee of $25.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice. Accord Dental, Professional LLC charges $25.00 for returned checks. If you have questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I understand if I have an unpaid balance to Accord Enterprises Professional LLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Accord Enterprises Professional LLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Accord Enterprises Professional LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____

Patient, Parent, or Guardian Signature Date

_____

Printed Patient Name