Ryan P. Estes, D.M.D **Allison K. Marlow, D.D.S.**

8136 Mall Road, Florence, KY 41042 ryanestesdmd@gmail.com

(859) 371-6543

Welcome to our Practice

Patient First Name:_____ Last:_____ MI:_____

Gender: ◯ Male ◯ Female Birth Date:_____ SS#:_____

Address: _____ APT/ Suite:_____

_____

Phone:

Mobile:_____ Home:_____ Work:_____

Email Address:_____

Emergency Contact: (Name, Relation, Phone)

_____

Employer Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both

Employer Name:_____ Phone:_____

Address:_____

Primary Dental Insurance

Name of Subscriber:_____ DOB:_____ SS#:_____

Subscriber Address:_____

Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Employer Name:_____

Insurance Plan Name:_____ ID#_____

Insurance Provider Phone Number:_____ Group/ Client #:_____

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Secondary Dental Insurance

Name of Subscriber:_____ DOB:_____ SS#:_____

Subscriber Address:_____

Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Employer Name:_____

Insurance Plan Name:_____ ID#_____

Insurance Provider Phone Number:_____ Group/ Client #:_____

Insurance Authorization:

◯ By checking this box, I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understands that I am financially responsible for all charges, whether or not paid by insurance.

Medicare Opt-Out Private Contract

Dentist represents that we are excluded from participation under the Medicare Program both patient and dentist acknowledge that patient is not experiencing an emergency health situation.

Patient Acknowledges: Not to submit a Medicare claim or request Dentist to submit a claim even if they are covered under Medicare for any services provided.

Patient is fully responsible for payment of services and no reimbursement will be provided under Medicare for the services. The patient will be responsible for payment of services at the Dentists' usual rate and regular payment agreements. Medigap and other supplemental insurance plans do not or may not elect to cover services as payment is not made under Medicare. Patient has right to have other providers provide services. Patient is not required or compelled to enter into private contracts that apply to other Medicare covered services furnished by other dentist who have not opted out. Patient agrees to reimburse Dentist for any costs and reasonable attorneys' fees that result from violation of the Agreement by patient and his/her beneficiaries.

Contract is in effect from date of signature until end of Dentist's end of opt out period.

Signature_____ Date:_____

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred for their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms as an out-of network provider and/or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

◯ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

HIPPA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

◯ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

I authorize this dental practice to release any financial or dental information to the following person(s)

Name(s):_____

Signature_____ Date:_____