Financial Policy Agreement

The Tooth Doc
Marty J. Matz, D.D.S.
15751 W.Dodge Rd.
Omaha, NE 68118

Appointments

- We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we would appreciate a 48 hour notice.
- If you are late for your appointment, it may be necessary to reschedule your appointment.
- A $25.00 fee may be charged for missed appointments.
- We reserve the right to terminate the doctor-patient relationship.

INSURANCE

- Deductibles, estimates, and services not covered by insurance are due the day of service.
- It is the patient's responsibility to keep their account updated with current insurance information.
- It is the responsibility of the patient to understand their benefit plan.
- Insurance payments that are not paid to our establishment within 45 days of billing become the responsibility of the patient.
- Patients with insurance coverage that pays the individual directly are responsible for the entire balance on the day of service.
- I authorize assignment of the insurance rights and benefits directly to the office for services rendered.

ADJUSTMENTS

- A 5% appreciation adjustment is offered when payment is made in full on the day of service with a credit card, for patients who do not have insurance, or patients with insurance on procedures that are not covered.
- A 10% senior adjustment is offered for patients who are 65 and older and payment is made in full on the day of service.

Account Balances

- A monthly statement will be mailed once insurance payments have been applied. The remaining balance is the responsibility of the patient and is to be paid in full upon receipt. Billing or accounting errors are to be reported immediately upon detection.
- A $10.00 late fee will be charged monthly on accounts that are delinquent.
- Returned checks are subject to a $30 fee.
- A finance charge will accrue on accounts 60 days and older.
- Account balances 90 days and older will be sent to a collection agency, therefore terminating the doctor-patient relationship.

I have read and agree to this Financial Policy.

Patient_____

Signature_____ Date_____

HIPAA Information and Consent

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The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A Notice of Privacy Practices should be available to you in the office. The notice provides you information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U.S.Department of Health and Human Services.
By signing below, you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

Patient Name_____

Relationship to Patient (if applicable)_____

Signature_____ Date_____

MEDICAL HISTORY

The mouth is connected completely to the body. Full disclosure of your medical history is mandatory for us to treat you properly.

Physician's Name _____ Phone# _____ Date of last visit _____

(Women) Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Please list all allergies environmental, food and medications _____

_____

_____

Please list all medications you are currently taking, including over-the-counter and herbal supplements _____

_____

_____

PLEASE PUT A CHECK MARK BY ANY CURRENT CONDITION OR PAST CONDITION:

- ☐ AIDS
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Persistent Cough or Coughing Blood
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Drug Addiction
- ☐ Cortisone Treatment
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Disease
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Seizures
- ☐ Fainting
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Surgery (including stents)
- ☐ Hepatitis A, B or C
- ☐ Jaw Pain or Locking
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Panic Attacks
- ☐ Pacemaker / Defibrillator
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Heartburn (Gastric Reflux)
- ☐ Venereal Disease (STD)
- ☐ Allergic Reaction to Latex
- ☐ Allergic Reaction to Local Anesthetic
- ☐ Resistance to Local Anesthetic
- ☐ Complication after a dental procedure
- ☐ Sleep Apnea / difficulty sleeping
- ☐ Any Other Condition Not Listed

(please explain)

_____

_____

_____

Do you have any immediate family with any conditions listed above, or is there any family dental history you would like to make us aware of?

_____

_____

_____

I understand that the above information is necessary to provide me with dental care in a safe manner. I have answered all questions thoroughly, to the best of my knowledge. I give Dr. Matz authority to take any necessary x-rays, study models, photographs or any other diagnostic aids in order to make a thorough diagnosis. Employing the services of Dr. Matz through the acceptance of presented treatment implies my consent to treatment. Acceptance of treatment also makes me responsible for payment regardless of insurance reimbursement (per Office Financial Policy Statement). *I also authorize assignment of the insurance rights and benefits directly to the office of Marty Matz, D.D.S. for services rendered.

Signature (patient or legal guardian of patient) _____ ***Date*** _____

FOR OFFICE USE:

_____

_____

_____

_____

_____

_____

_____

The Tooth Doc

Marty J. Matz, D.D.S.

Health History & Registration

Patient Information

Name: First _____ MI ____ Last _____ Nickname? _____

Minor __ Married__ Single__ Widowed__ Birth-date___/___/_____ Gender: Male___ Female___ Social Sec. # _____-_____-_____

Phone #'s: Hm _____ Cell _____ Work _____

I prefer appointment confirmation by: ☐Home phone ☐Work phone ☐Cell phone ☐email ☐text

What is your preferred day for dental appointments _____ What is your preferred time _____

Preferred email address (may be used to confirm appointments)_____

How did you hear about our office? _____

Home Address _____

City _____ State _____ Zip Code _____ Employer/Occupation _____

Spouse's Name_____ Phone # _____

Emergency Contact Person Name _____ Phone # _____

Responsible Party Information

Name of person financially responsible for this account (if different than patient)_____

Relationship to patient _____ Phone#_____ Work#_____

Address _____ City _____ State ____ Zip _____

Social Security # _____ Driver's License # _____

Primary Insurance Information

Name of Insured _____ Relationship to patient _____

Birth-date _____ Social Security # _____-_____-_____ Work Phone _____

Name of employer _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Subscriber ID #_____ Group #_____

Insurance Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

(If applicable)

Name of Insured _____ Relationship to patient _____

Birth-date _____ Social Security # _____-_____-_____ Work Phone _____

Name of employer _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Subscriber ID #_____ Group #_____

Insurance Co. Address _____ City _____ State _____ Zip _____

Dental History

Former Dentist _____ Last examination _____

Rate your level of dental fear ☐ None ☐ Some ☐ A lot

List any serious dental conditions you have been treated for (i.e. periodontal/gum disease, oral cancer, dental implants, treatment from a specialist)

_____

_____

_____