PRAY FAMILY DENTISTRY 2023

218-A East Shockley Ferry Rd. Anderson, SC 29624 (864)226-4411

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, **please fill out this form completely in ink.** If you have any questions, please ask us and we will be happy to help. **Please arrive 15 minutes prior to your appointment time** to allow us to verify insurance or to fill out any other paperwork.

Today's Date_____

Personal Information: Birth date_____ Soc. Sec. # _____

Name _____ Wishes to be called _____M/F (Please Circle)

Address_____

Home Phone _____ Cell Phone_____Email_____

May we contact you by email? Yes/No May we contact you by text message? Yes/No

Employer_____Occupation_____

Do you have new Insurance? Yes/No ** **If yes please give card to front desk staff to make a copy** **

Referred by_____

In the event of an emergency, who should we contact? Name_____

Relationship_____ Phone #_____

Responsible Party:

Are you the responsible party for this account? Yes/No (If no, please complete below)

Name _____Relationship to patient_____

Birthday_____ Soc. Sec.#_____

Address_____

City, State, Zip_____

Home Phone _____ Cell _____

Employer _____Work Phone_____

Dental Insurance Information: _____

Name of Insured: _____ Relationship to Insured: ___Self ___Spouse ___Child ___Other

Insured SSN: _____Insurance ID #_____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Insurance Company Phone Number: _____

Written Financial Policy

Thank you for choosing our office. 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 as manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, Master Card or American Express

-NO INTEREST Payment Plans from CareCredit®

- Allows you to pay overtime with NO INTEREST
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

Please Note:

_____This office will be happy to work with your Insurance carrier to maximize your benefits, and directly bill them for reimbursement on your behalf as a **courtesy** to you. **HOWEVER, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier**. Any request from your insurance company only delays payments. A charge of $18.00 will be added to re-file any insurance claims.

We offer a 5 to 10% courtesy for Senior Citizens (62 years old and up) who pay in full prior to completion of care. This courtesy is only offered for seniors with no dental insurance.

_____ Broken appointment fees of $35.00 up to $50.00 (depending on appointment type) will be charged for patients who miss or cancel without at least a 24-hour notice.

_____We will charge a fee of $35.00, for all returned checks.

_____**I authorize and request my insurance company to pay directly to the dentist.**

_____By checking this box, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

Call me____ Text me____ Call me and text me____

_____ Permission for Treatment and Promise of Payment

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs. I also accept responsibility for any service charges on past due accounts, associate charges for broken appointments, and all reasonable attorney fees incurred in the collection of those fees.

_____

Patient, Parent of Guardian Signature Date

_____

Patient Name (Please Print)