NEHA P. SHAH, DMD♦11 Deerfield Place♦Flanders, NJ 07836♦973.668.5020

Office Policy

PATIENT INFORMATION:
Name_____
Referring Dentist_____

PRIMARY INSURANCE INFORMATION:
Name of Insured (if other than the patient): _____
Relationship to Patient_____ Social Security Number of Insured: _____
Dental Insurance_____ Date of Birth of Insured:_____
Employer of Insured: _____ Group Number: _____
ID/Subscriber #: _____ Insurance Phone Number: _____

SECONDARY INSURANCE INFORMATION:
Name of Insured (if other than the patient): _____
Relationship to Patient_____ Social Security Number of Insured: _____
Dental Insurance_____ Date of Birth of Insured:_____
Employer of Insured: _____ Group Number: _____
ID/Subscriber #: _____ Insurance Phone Number: _____

Providing you with superior periodontal care to maintain your optimum dental health is our first priority.

- We make all payment arrangements in advance so you as a patient and we as your caregiver can focus completely on your dental treatment.
- For your convenience, we accept the following methods of payment: Cash, Checks, Debit, & Credit Cards. *We also participate in Care Credit, a no-interest financing option*. Please contact us for more information.
- ***Your estimated co-payment is due at the time of your visit. Although our office will do our best to determine your insurance benefits, ultimately it is your responsibility to pay any unpaid balance. We cannot know until services are COMPLETED what the insurance company will actually pay.***
- In the event we are not able to collect payment, we are obligated to inform you that your case will be referred to a certified collection agency. If your account is sent to collections you will be responsible for up to an 18% interest yearly on your balance as well as 30-50% of collection agency fees on your unpaid balance.
- We strive to provide you with the utmost, effective, and convenient care possible. With this in mind, it is understandable why we value the time scheduled for your appointment. This time is reserved especially for you. Our policy requires 2 business days notification for all cancellations.
- If at any time, you have concerns regarding financial matters with our office, please contact us immediately so we may assist you.

Welcome to our practice!

I have read and understood the above agreement.

_____ _____ _____

Patient Name Patient Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

NEHA P. SHAH, DMD
11 DEERFIELD PLACE
FLANDERS, NJ 07836
973.668.5020

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and individually.
- Obtain payment from third party payers. (e.g. my insurance company)
- Conduct normal health-care operations such as quality assessments, dentist certifications, request x-rays, records, and reports

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of any health information. 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 above to receive a current copy of the Notice of Private 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 that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____ _____

Patient Name Patient Signature Date

Authorization to Release Information:

I authorize the above named dentist to provide any insurance company, claim administrators, and consulting healthcare professional, information concerning health care, advice, treatment, or supplies provided. This information will be use exclusively for the purpose of evaluation and administering claims for benefits.

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

_____ _____ _____

Patient Name Patient Signature Date