

Paige Prather Smiles

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**Please complete this paperwork at least 2 days prior to your appointment.
Please only use dashes (-) when entering phone numbers.**

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * _____ * _____
Last First MI Preferred Name

Title: _____ **Gender:** * Male Female **Family Status:** * Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: * _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ * _____
Home Mobile Work Ext Fax Other

Address: _____ * _____ * _____ *
Address 1 Address 2
City State Zip Code

In case of emergency, who is to be notified? (Please provide best contact phone number)

We send appointment updates to notify you of an upcoming appt. 1 week and 1 day in advance. How do you prefer to receive these notifications? *

Phone Call Text Msg Email

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Dental Insurance Information

* I authorize Dr. Paige M Prather, PLLC, to release any and all identifying health information that will be necessary in filing a claim with my dental insurance carrier. I agree for all benefits to be paid to Dr. Prather. I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

ID Number: (Located on Front of your insurance card, may also be labeled as Enrollee ID #, sometimes the same as your Social Security #) If none please state "none".

Social Security Number and Date of Birth of Insured (Policy Holder)

Insurance Provider Contact Phone Number (Located on Insurance Card):

Please verify that the information you have provided is correct. It is your responsibility to provide us with accurate information about your insurance coverage. Failure to do so can result in delay of payment or declination of payment by your insurance and you will have to assume full responsibility for the cost of service.

Minor/Child Agreement:

- I understand that any parent, who brings in a minor for treatment, is responsible for that patient's account balance. A Guardian must remain in the office for the entire duration of a minor's treatment. No patient, under the age of 18, will be treated without a documented guardian present in the office. I verify that I am the parent/guardian of the said patient and there are no court orders now in effect that prohibit me from signing this form. I do hereby authorize the dental staff of Dr. Paige Prather to perform any necessary dental services for the stated minor. Should a child be "dropped off" or left without an attending guardian, the dependent's appointment will be cancelled and charges will apply.

Cancellation Policy

- * Your appointment time is especially reserved for you. We value your time and we ask that you value the time of our doctor and other patients. Having an accurate schedule allows our team to provide each patient with maximum attention and allows us to keep more closely to your scheduled appointment time. We pride ourselves on little to no wait time. A \$75 cancellation fee will be applied for any appointment 1 hr. or less in length canceled without 2 business days notice. Down payments are required to schedule any appointment over 1 hour in length. These down payments are nonrefundable if cancelled without 2 business days notice. Cancellation of a sedation appointment will differ from this basic policy and these terms will be reviewed at the time of booking the appointment. If you arrive more than 20 minutes late you will be asked to reschedule your appt. out of consideration for our other patients' time and a cancellation fee will apply. If you cancel more than 2 times without 2 business days notice within a period of 6 months, you will be moved to our Priority Scheduling list, meaning appointments cannot be scheduled more than one day in advance of the appointment time. We provide complimentary reminders of your appointment via text, email, and phone calls. Most of our patients greatly appreciate this service. You may choose the reminder method that works best for you or opt out of this service entirely. However, all cancellation policies still apply. If you have questions or concerns about this policy, please consult with a team member prior to scheduling an appointment.

Financial Policy: Please read over thoroughly prior to receiving services.

- * Payment is due, in full, at the time of service. We can accept Cash, Mastercard, Visa, Discover, American Express, Care Credit and insurance checks. We accept personal checks from patients with a record of 6 months with our practice. We charge a service fee of \$30.00 for any check that is returned.
- * As a courtesy for insured patients, a claim is filed on the date services are received. We collect upfront for a portion of the services provided to help cover our immediate expenses and extend credit for the remaining amount for up to 60 days. Payment should be remitted from your insurance carrier within 30 days of that service date. If at 30 days, your claim is still unpaid you may receive a statement and we encourage you to contact your insurance carrier directly to ensure timely payment of the claim. We can resubmit your claim if necessary at 30 days. At 60 days if the claim is still unpaid, the balance becomes your responsibility or the responsibility of the guarantor of the account and is due and payable at this time. Failure to pay at this time upon notification will result in late fees and finance charges at a rate of 8%

Insurance Policies have specified restrictions that limit a patient's treatment. If you choose to receive the services prescribed by Dr. Prather and they are not covered by your insurance, all costs associated with the non-covered services are your full financial responsibility. We always base treatment recommendation on what is best for you and your overall health, not on what insurance will cover. If you would like to verify your out of pocket expense, please contact your insurance carrier directly. We cannot guarantee payment from insurance carriers.

- * HIPAA NOTICE: Notice of Privacy Practices: Effective Date of Notice: January 24, 2007. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. This Notice is available at any time, for your review or personal copy, in the reception area of our practice. By checking this box you are confirming knowledge of your rights to privacy as a patient and the receipt of this Notice.

* **By checking this box, I acknowledge that the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I/my minor have any changes in contact/personal information. I realize that failure to do so can result in inability to reach me and or provide products and or notifications regarding my treatment and health and that additional costs may be incurred because of this.**

We will have you sign this paperwork electronically upon arrival to our office. Upon signing you are stating you understand and agree to comply with all policies as outlined in this document.

Signature _____ Date _____

Response Date:

____/____/____