Dr. Amanda Seay

Patient Information

Patient Name: _____ Date:_____
Last First MI

Male ☐ Female ☐ ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security # _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____ Driver's License #: _____

Address: _____
Street & Apt. # City State Zip Code

Whom may we thank for referring you to our practice? _____

If not referred by a patient, please let us know how you heard about us. _____

Emergency Contact Information

Name: _____ Phone #: _____Relationship to Patient: _____

Insurance Information (Reimbursement will be sent directly to you)

Primary

Name of Subscriber: _____ Is subscriber a patient? YES or NO
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Insurance Company Phone Number: _____ Subscriber's Employer Name: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Your initial appointment must be paid for on the day services are rendered. Any insurance benefits will be filed for you and reimbursable insurance checks will be sent directly to you. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. If your account becomes past due, we will take necessary steps to collect the balanced owed. If we have to refer your account to a collection agency or small claims court, you agree to pay all of the cost/fees which are incurred. The finance charge will be computed at the rate of one and one-half percent (1 ½%) per month or an annual percentage ratio of eighteen percent (18%). I understand that the fee estimate listed for this dental care can only be extended for a period of ninety (90) days from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matter related to this form. **RESERVED APPOINTMENT TIMES** – Patient visits are the most important part of our day. We reserve time and prepare in advance for each patient's arrival. We strive to see our patients on time and have made this a priority to respect your busy schedule. If you are unable to keep your reserved appointment, we kindly ask for a 48 hour notice. We will assess a fee of $55 for last minute cancellations, missed appointments and short notice rescheduling. We will consider exceptions on an individual basis.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Privacy Practices Acknowledgement – HIPAA

I understand that Park West Dentistry strictly adhere to the ***Health Insurance Portability & Accountability Act of* 1996** ("HIPAA") including the OMNIBUS Ruling in order to protect my privacy as a patient. As a patient, I understand that my information can be used to conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly. It may also be used to obtain payment from the third party payers or conduct normal healthcare operations such as quality assessments and physician certifications. I understand that if I would like to read a detailed Notice of Privacy Practices, I may request to see one at anytime and one will be furnished. I may also view a copy online at www.amandaseay.net.

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian