GROTH DENTAL

Patient Profile

First Name _____ Last Name _____ Pref. Name _____

Date of Birth _____ Soc. Sec. # _____ Gender _____

Marital Status _____ Home Address _____

City _____ State _____ Zip Code _____

Home # _____ Cell # _____

Work # _____Ext _____ Occupation _____

Email _____ Emergency Contact _____

Phone # _____ Relationship to Patient _____

Appointment Preference

How do you prefer to be reached: ☐ Home # ☐ Cell # ☐ Text to Cell # ☐ Work # ☐ Email

My preferred appointment times are: ☐ Morning ☑ Afternoons ☐ Evenings ☐ No Preference

Referral Profile

How did you hear about our office? _____

Insurance Profile

Name of Insured _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec # _____ Date of Birth _____

Employer _____ Insurance Company _____

Insurance ID # _____ Group # _____

32100 Telegraph Road Suite 195
Bingham Farms, MI 48025
248-885-8247

GROTH DENTAL

HIPAA Authorization

I, (Patient Name or Legal Guardian) _____, authorize the practice of Groth Family Dental and its staff to provide any dental care necessary. I also authorize the release of any information related to treatment to other health care servicers (such as specialists, insurance companies…etc).

I further acknowledge receipt of this practice's Notice of Privacy Practices and rights to review the Provider's Privacy Requirements.

Signature of Patient or Legal Guardian _____ Date _____

Office Policies

At our office we believe in devoting our entire focus towards each patient. Please understand for this to happen we specifically reserve time in the schedule for your treatment needs. Due to the high demand for these appointment slots, the following office policies have been instituted:

THERE WILL BE A $50 FEE CHARGED TO YOUR ACCOUNT IF YOU MISS AN APPOINTMENT OR CANCEL WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME.

IF YOU HAVE RESERVED TIME WITH DR. GROTH, THE FEE WILL BE ASSESSED BASED ON YOUR TREATMENT PLAN AND THE LENGTH OF THE APPOINTED TIME MISSED.

IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR APPOINTMENT AND WE ARE UNABLE TO PERFORM THE PLANNED TREATMENT IN THE TIME REMAINING, WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.

Our staff wants to be available for your needs and the needs of all our patients; however, when a patient does not show up for a scheduled appointment, another patient misses the opportunity to be seen.

We thank you for being a valued patient and for your understanding of these office policies.

Signature of Patient or Guardian: _____ Date _____

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Our Financial Policy

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

You are responsible for payment of all services rendered. Payment in full is required at the time of service. We may accept assignment of your insurance benefits, but please understand your insurance policy is a contract between you and your insurance company. We have no influence on the terms agreed upon between you and your insurance company. We are happy to submit your insurance claim but we will need all of your insurance information. Failure to do so prohibits any claim submission and the entire balance will be due immediately. If a portion of your treatment will be covered by your insurance, we require your estimated co-pay portion to be paid at the time of service. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. The balance is your responsibility whether your insurance company pays or not. Please be aware some of the services provided may be non-covered services by the Insurance Program and/or other medical insurance. This is not a statement by the insurance company that the service was unnecessary, but rather a reason for rejection of payment by the insurance company.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Guardian: _____ Date _____

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