CAROLINA FAMILY DENTISTRY/RON BANIK, DMD, PC

8720-B North Park Blvd, N. Charleston, SC 29406

(CONFIDENTIAL)

PATIENT INFORMATION

First Name_____**MI**_____ **Last Name**_____**Preferred name**_____

Address_____**Birthdate** _____/_____/_____

Apt #_____ **City**_____**SSN** _____-_____-_____

State _____ **Zip Code** _____ **Marital Status: S**_____ **M**_____ **D**_____ **W**_____ **Gender: Male** _____ **Female** _____

Employer_____ Driver Lic# _____

Home Phone_____ **Work Phone**_____ **Ext** _____ **Mobile**_____

Email_____**Emergency contact**_____

Who may we thank for referring you to our dental office? _____

*****RESPONSIBLE PARTY*****
(if patient is a minor)

First Name_____MI_____ Last Name_____

Address _____ Apt # _____ City _____ State _____ Zip Code _____

Birthdate _____/_____/_____ **SSN** _____-_____-_____ Driver Lic# _____

Home Phone _____Work Phone_____ Ext _____ Mobile_____

Email_____ **Emergency contact**_____

*****INSURANCE INFORMATION*****

***Primary Insurance Company Name** _____**Policy ID#**_____

Subscriber's Name _____ Subscriber's DOB_____/_____/_____

Relationship to Patient: Self____ Spouse ____ Child____ Other____

Insured's Employer_____ Employer Address_____

***Secondary Insurance Company Name**_____**Policy ID#**_____

Subscriber's Name_____ Subscriber's DOB_____/_____/_____

Relationship to Patient: Self____ Spouse____ Child____ Other____

Insured's Employer_____ Employer Address_____

SIGNATURE_____ **DATE**_____/_____/_____

(PARENT/GUARDIAN IF PATIENT IS A MINOR) (Type name for e-signature)

Thank you for choosing our dental office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are available to answer your questions and/or assist you in any way we can.

Fees less than $350 are due and payable at the time of treatment is rendered. We accept cash, checks, credit/debit cards (MC, VISA, DISCOVER). Payment plans are also an option (please inquire). ***Scheduling lengthy procedures may require a deposit for down payment, please see financial or appointment policy for details.***

Patients with dental insurance: we are happy to assist in filing the necessary forms to help you receive the full benefits of your dental coverage. The insurance relationship constitutes as agreement ***between the carrier and the insured***. As such, we can make no guarantee of the estimated coverage payment. However, please know that we will do everything possible to see the patient receives the full benefits of the insurance policy.

Carolina Family Dentistry/Ron Banik, DMD, PC

********** APPOINTMENT POLICY/INFORMED CONSENT**********

IMPORTANT! PLEASE READ!

Our dental office is dedicated to quality care and exceptional service in a timely manner. We strive to accommodate the busy schedule of every patient, therefore we ask that when an appointment is scheduled with Dr. Banik, that you make every effort ***not to change*** your reserved dental appointment time. However, we do understand emergencies arise and are happy to work with you to accommodate unforeseen events. ***If you must change your appointment, please let us know at least 48 hours in advance.*** Continual failed or broken appointments not only create scheduling problems for other patients of our dental practice, but also result in costly delays or more extensive treatment. Please make your dental health a priority by making every effort to keep for your reserved dental appointments so that we can treat you in the most efficient, cost effective, and timely manner. Thank you for your understanding and cooperation!

PLEASE NOTE THE FOLLOWING:

- Failure to keep and/or continuously canceled appointments with less than 48 hrs are considered broken appointments and may be subject to cancellation fees.
- For multiple broken appointments and/or repeated `cancellations with less than 48 hrs, you may be required to place a **DEPOSIT OF AT LEAST $25 OR 10% OF SERVICES FEES** to reschedule your appointment or secure your appointment with a credit card. Any deposits made will be fully applied to your account balance. **HOWEVER PLEASE NOTE: If the appointment is missed or changed with less than 48 hr notice then loss of deposit may result. If your appointment was secured with a credit card, cancellation fees may be charged to it.**

I give my **informed consent** to have dental procedures performed and/or medications administered by the dental team of Carolina Family Dentistry/Ron Banik, DMD, PC. I understand and consent to changes or additions that may be necessary due to unforeseen complications while treatment is in progress. I also give Carolina Family Dentistry/Ron Banik, DMD, PC permission to use photographs, videos, and/or x-rays for promotional and educations purposes only.

I have read, understand, and agree to the above policies.

Patient signature_____ Date_____
(Parent/Guardian if patient is a minor)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Probability & Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used only to:

1. Conduct, plan, and direct my treatment and follow-up with other healthcare providers.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Please print) _____ Relationship to Patient_____

Signature _____ _____ _____ Date_____
(Parent/Guardian if patient is a minor) (Type name for e-signature)

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Form, but was unable to do so as documented below.

Date_____ Initials_____ Reason_____

CAROLINA FAMILY DENTISTRY/RON BANIK, DMD, PC

8720 North Park Blvd | Suite B | N. Charleston, SC | 843-553-0911

Financial Policy

Thank you for choosing Carolina Family Dentistry. 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 and manageable for patients as possible by offering several payment options.

Payment Options:

- Cash or check

  We offer a 5% courtesy discount to patients who pay for their treatment with cash or check prior to completion of care with an out of pocket expense of $350 or more.

- Credit Card: *VISA, MASTERCARD, OR DISCOVER*
- Payment Plans with ***CARECREDIT -NO INTEREST*** *(6 or 12 month plans only)**
  - Convenient, low monthly payment plans* (go to bottom of page)
  - No annual fees or pre-payment penalties* (go to bottom of page)

Please note:

Carolina Family Dentistry requires payment during your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment of $250 of more a 10% deposit is required to secure your initial treatment appointment. Also, a deposit may be required to reserve future appointment time due to excessive missed appointments without sufficient notice.

As a courtesy for patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. ** (go to bottom of page)

A fee of $25 is charged for patients who miss or cancel more than 2 appointments in a twelve month period without a 48-hour notice.

Carolina Family Dentistry charges *$30 for returned checks*.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I understand and acknowledge that I am financially responsible for the services provided for myself or dependent(s) by Carolina Family Dentistry/Ron Banik, DMD, PC. regardless of insurance coverage.

Patient/Responsible party signature_____Date_____

(Parent/Guardian if patient is a minor) (Type name for e-signature)

Patient/Responsible party name (please print) _____

***If paid within the promotional period (6 or 12 months). Otherwise, interest is accrued and assessed from original purchase date.**
Minimum monthly payment required. **Subject to credit approval**. Visit *CareCredit.com* to apply or for more information.

**If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.