MICHAEL S. CONNALLY DDS
Cosmetic & Implant Dentistry

POLICIES

432-684-8289 / 432-520-4507

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express and Discover. Financing is available with approved credit. Ask for details.

A minimum charge of $30.00 will be made for broken appointments and appointments cancelled without 24 hours notice. Our fee for returned checks is $25.00.

We do not send monthly statements. Therefore, for any balance remaining after insurance has paid you will receive one statement which is due immediately and in full. Any delinquent balance is subject to interest and will be given to a collection agency after 30 days.

OUR INSURANCE POLICY

We will gladly discuss the cost of treatment and answer any questions relating to your insurance, realizing that:

INSURANCE CONTRACT: Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

"U.C.R.": Most insurance companies pay based on "U.C.R.", which is the arbitrary amount allowed by your policy for each covered procedure. If your coverage is based on a fee schedule it is necessary for you to provide us with a copy of such schedule. We are not contracted with any insurance company as a preferred provider and do not adjust our fees according to what insurance does or does not pay. You are responsible for all amounts not covered by insurance.

ARBITRARY EXCLUSIONS: We diagnose and perform treatment based on ***dental necessity*** not insurance coverage. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will be happy to help you process your insurance claim form and, in most cases, accept assignment, if all necessary information is provided prior to the appointment. If you are "double covered" we must disclose that information to your primary carrier, however we do NOT accept assignment on secondary coverage. It will be your responsibility to pay your deductible and estimated percentage not covered by insurance at the time services are rendered. We base our *estimated* out of pocket amounts on our experience with many different coverages over the last several months. We do not use amalgam (silver) filling material. For bonding-type composite fillings done on posterior teeth your estimated portion will be approximately 50% of our fee. Most policies have procedures that are not covered. In order to get a more accurate estimate of what insurance will pay, a pre-treatment estimate will be necessary. However, response time is usually very slow (6 weeks or longer). In many cases the postponement of dental treatment may be detrimental. Therefore, we do not usually suggest waiting for the pre-treatment estimate.

OUR DENTAL RECORD POLICY

In the event another provider of dental service needs to view our radiographic records, duplicates are made and usually sent directly to the provider. In some cases, there is a fee associated with the duplicating of films.

We must emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are YOUR responsibility from the date the services are rendered. A copy of this policy is available for your records upon request.

Signature (Responsible party) _____ Date _____

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DENTAL AND MEDICAL HISTORIES / UPDATES

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____
Height: _____ Weight: _____
Women (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery *	☐	☐	Bruise Easily/Blood Disease	☐	☐	Emphysema	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Aredia I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Lung Disease	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Shortness of Breath	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt	☐	☐	Frequent Cough	☐	☐	Diabetes	☐	☐	Venereal Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Hepatitis A (infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
						Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen? *	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____

Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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Cosmetic & Implant Dentistry

PATIENT INFORMATION

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PATIENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBILE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE)MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE)MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?

☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wiish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within ____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of $_____ for a balance under $_____)which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.