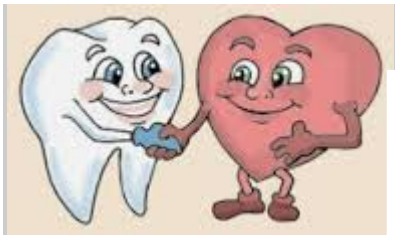

Emilie Russo Schenck, D.D.S.

Keeping you and your smile healthy.

Welcome to our Dental Home!

PATIENT INFORMATION:

Last Name:_____ First Name:_____ Preferred to be called: _____

Mailing Address:_____ Date of Birth:_____

City, State, Zip:_____ SS#:_____ Sex:___ M ___ F

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Do you prefer being contacted via: phone call, email or text?

Driver's License:_____ E-mail Address:_____ Occupation:_____

Employer:_____, Address, City, State, Zip_____

Emergency Contact Name:_____Phone#_____Relation:_____

How did you hear about our office? _____**If referred, whom may we thank for their trust in us?**_____

INSURANCE INFORMATION:

Primary Insurance Company:_____Address:_____

City:_____State:_____Zip:_____Phone #:_____

Policy Holder Name:_____ Member's ID:_____ Birth Date:_____

Policy Holder's SS#_____ Group or Policy #_____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Emilie Russo Schenck of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that my estimated portion is to be paid at the time of treatment, unless other financial arrangements have been previously arranged. I understand that my dental insurance is a contract between me and the insurance company and not between Dr. Schenck and my insurance company. I fully understand that the balance is my responsibility regardless of insurance coverage.

Date:_____ Signature:_____

ACKNOWLEDGEMENT AND CONSENT

1. The undersigned hereby authorizes Dr. Schenck or her designee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize Dr. Schenck or her hygienist to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I authorize and consent that Dr. Schenck and/or her hygienist choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that it is my responsibility to advise the appropriate office staff of any changes in the information contained on this form.
3. I certify that I have read and understand all of the information above and that, to the best of my knowledge, all of the information provided by me is accurate and correct.

Patient Name(Print):_____Date:_____

Signature of Patient, Parent or Guardian: _____ Relationship:_____

MEDICAL HEALTH HISTORY---Are you aware your dental health is directly related to your overall medical health?

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain:_____
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain:_____
4. Yes No Are you being treated by a physician now? For what?_____

Who is your PCP or physician you see on a regular basis and phone number:_____

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of Breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in ears
17. Yes No Frequent headaches
18. Yes No Fainting spells
19. Yes No Blurred Vision
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth
24. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

25. Yes No Heart Disease
26. Yes No Heart attack, heart defects
27. Yes No Heart murmur
28. Yes No Rheumatic fever
29. Yes No Stroke, hardening of arteries
30. Yes No High blood pressure
31. Yes No TB, emphysema or other lung diseases
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes
35. Yes No Mitral Valve Prolapse
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease
40. Yes No Skin disease
41. Yes No Anemia
42. Yes No VD (syphilis or gonorrhea)
43. Yes No Herpes
44. Yes No Kidney, bladder disease
45. Yes No Thyroid, adrenal diseases
46. Yes No Do you have a family history of diabetes, heart problems, or cancer ?

D. DO YOU HAVE OR HAVE YOU HAD:

47. Yes No Surgeries_____
48. Yes No Blood Transfusions _____
49. Yes No Artificial Joint_____
50. Yes No Prosthetic cardiac valve or repair_____
51. Yes No Infective Endocarditis (IE)_____
52. Yes No Contact Lenses_____
53. Yes No Psychiatric Care_____ _____
54. Yes No Radiation treatments
55. Yes No Chemotherapy
56. Yes No Prosthetic heart valve
57. Yes No Pacemaker
58. Yes No Birth control pills (**women only)**
59. Yes No Pregnant or nursing (**women only)**

E. DO YOU TAKE OR HAVE TAKEN:

60. Yes No Recreational drugs
61. Yes No Alcohol
62. Yes No Tobacco in any forms
63. Yes No Phen Phen diet pills or any other diet pills
64. Yes No Fosamax (or any other medication for osteoporosis or low density bones)

F. VITAMINS & MEDICATIONS:_____

_____

_____

65. Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

66. Yes No Have you ever been told by a physician or dentist that you need to premedicate prior to any dental treatment?

ALLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list any allergies:

_____

_____

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____

{Signature of Patient and/or Guardian} {Date}_____

(Relationship to Patient} Self or Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify)

_____

_____

Emilie Russo Schenck, D.D.S.

Our Financial Philosophy and Agreement

To create an understanding and partnership in the settlement of your account, No Surprises!

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family.

Patient's Role: As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone. In developing a financial arrangement it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

Missed Appointments: We respect your time. We do not double book or over book appointments. We have patients waiting for appointments. Please cancel and/or make any necessary changes **at least two business days prior** to your appointment, there will be a $50 charge for a broken/missed/changed appointments without 2 business days advance notice. This fee is not billed to your insurance or paid by your insurance. If you are not sure if you will be able to keep the appointment, we will be glad to move the appointment to a day that you know you can be here. We will also do our best to fit you in on a day that you know you can be here if you call the morning of the day you can come in, or place you on the SHORT NOTICE list in case an appointment becomes available.

Insurance: We will file your insurance claim for you**, as a courtesy to you.** do not tell us every clause, exclusion, limitation, etc. We give a guestimated portion for treatment from We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We request coverage information from your insurance, however, they the information that we receive from your insurance company. Your portion is due at the time the services are rendered**. *Please become familiar with your own policy*,** you are your best advocate. If your insurance company has not paid on your claim within 30 days, the full balance will automatically be transferred to you. That balance will be due upon billing. We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due upon notice. Please provide permission to process your credit card for any portion not covered by insurance, remaining balance after insurance payment is received. We will call to inform you of the balance and get verbal authorization before any charges are made to your card.

WE OFFER ACCESS TO EXTENDED PAYMENT PLANS

Payment Plan: We offer interest free finance for up to 6 months and low interest for extended periods or time through Care Credit. Please let us know if you would like additional information on this payment plan. Care Credit does not allow charges for treatment that will not be done within 30 days. If you decide not to finish treatment, for any reason, there is a fee to refund any portion that may be owed to you and will be refunded to your Care Credit plan.

WE ACCEPT CASH, CHECK OR MASTERCARD, VISA and DISCOVER

Checks : A copy of your driver's license is required to accept a payment by check. There is a **$35 service fee,** plus any bank charges, for any checks returned by the bank for any reason. This $35 plus any bank charges will be added to your account, and payment is due by cash or money order within 5 business days of notice to you. It is in violation of Louisiana law to write a "worthless check", if not paid by the time allowed it will be turned over to the District Attorney's office for prosecution and additional fees will be applied by them. At that point you must make payment directly to the District Attorney. Any future payments must be made in cash or by credit card (Visa, MasterCard).

Delinquent Accounts: After **30 days** the balance is owed by you and a notice is sent to you, if your insurance has not paid by that time we request that you call your insurance company and then call us. When you receive a notice, please call with any questions so that it can be handled in a timely manner. Any unpaid balance after 45 days is charged a yearly finance charge of 18% but no less than $5. *Please ask for the Pre-Authorized Credit card form to avoid this fee* -verbal authorization is required before any charges are made to your card so please return the call promptly. If the account reaches collection status (90 days) and sufficient effort has not been made to pay off my account, my account will be assigned to a collection attorney or agency. A Collection fee of $30 will be charged to your account at that time. **If Dr. Schenck must take additional steps to collect the account, ALL cost of collection, including court cost and attorney's fees incurred by Dr. Schenck will be owed by you.**

Legal Fees/Other Fees: You will be responsible for any legal fees associated with collecting your account. If you are taken to small claims court for non-payment of your bill, you will be responsible for all fees and/or charges.

Waiver of Confidentiality: If your account is submitted to collections, and if it becomes necessary to litigate in court, or if your past-due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: X-rays are the property of doctor and the fee charged is to read those x-rays only. You must request in writing, and pay a reasonable fee if you want to have copies of your records sent to another doctor, organization, lawyer, etc. The amount of the fee is determined by Louisiana state law ($25 for the first page and $1 per page after that). You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We will require approval/authorization by the Workers Compensation carrier prior to your initial visit in connection to the injury.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification and payment from your attorney prior to your initial visit. Payment of your bill remains your responsibility. We cannot wait for payment until the outcome of your lawsuit or claim. We cannot bill your insurance.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and in effect.

I have read, understand, and agree to the above Practice Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

Patient's Name (please print): _____

Patient's Signature: _____

OR

Signature of Responsible Party: _____

Relationship: _____ Date: _____

Witness:_____ Date:_____

We will be happy to give you a signed copy of this policy for your records.