DR. P. BOSTANI'S OFFICE FINANCIAL POLICY

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM PATIENTS FOR THE COST INCURRED IN THEIR CARE AND FINANCIAL RESPONSIBILITY ON THE PART OF THE PATIENT MUST BE DETERMINED BEFORE TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR POLICY, WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO ANY TREATMENT.

USUAL AND CUSTOMARY FEE'S

OUR PRACTICE PROVIDES THE VERY BEST TREATMENT FOR OUR PATIENTS, USING THE BEST TECHNOLOGY AND MATERIALS. WE CHARGE A FAIR FEE COMPETITIVE WITH OTHER OFFICES IN OUR AREA THAT PROVIDE SIMULAR QUALITY OF SERVICES.

PAYMENT OPTIONS

- PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
- WE ACCEPT CASH, CHECKS (EXCEPT ON THE FIRST APPOINTMENT), MASTERCARD, VISA AND DISCOVER.
- A 5% REDUCTION IN FEE'S WILL BE OFFERED IF COMPLETE PAYMENT IS MADE IN ADVANCE OF TREATMENT BEING RENDERED, BY CHECK OR CASH.
- ALL INSURANCE DEDUCTIBLES AND CO-PAYMENTS ARE DUE PRIOR TO TREATMENT.

INTEREST CHARGES

OUR OFFICE DOES NOT PROVIDE A BILLING SERVICE, AND IN AN EFFORT TO AVOID PASSING ADMINISTRATIVE CHARGES ON TO OUR PATIENTS OUR POLICY IS FOR ALL ACCOUNTS TO REMAIN CURRENT. ACCOUNTS THAT HAVE NOT BEEN PAID WILL NOT BE SUBJECT TO FINANCE CHARGES AT THE RATE 3.0%, AND MAY BE SUBJECT TO COLLECTION ACTIVITY.

INSURANCE ON ASSIGNMENT

WE MAY ACCEPT ASSIGNMENT OF INSURANCE BENEFITS, HOWEVER ALL DENTAL SERVICES FURNISHED ARE CHARGED DIRECTLY TO YOU THE PATIENT, AND THE BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT, REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION I= OF USUAL AND CUSTOMARY SERVICES.

WE REQUIRE YOUR INSURANCE INFORMATION AND AN ORIGINAL CLAIM FORM. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PART OF THAT CONTRACT. PLEASE BE AWARE THAT SOME OR PERHAPS ALL OF THE SERVICES PROVIDED MAY BE NON-COVERED SEVICES. CLAIMS ARE SUBMITTED PROMPTLY AFTER TREATMENT IS RENDERED. INSURANCE COMPANIES ARE OBLIGATED TO REIMBURSE A VALID CLAIM WITHIN 30 DAYS TO THE PATIENT, AND WE WILL MAKE EVERY EFFORT TO RECEIVE PAYMENT ON UR BEHALF. HOWEVER IF YOUR INSURANCE COMPANY HAS NOT PAID YOUR ACCOUNT IN FULL WITHIN 60 DAYS, THE BALANCE OF YOUR ACCOUNT WILL BE BILLED TO YOU. OUR OFFICE PRIDES ITSELF ON HELPING OUR PATIENTS MAXIMIZE THEIR BENEFITS, AND WE WILL CONTINUE TO ASSIST YOU IN ANY WAY WE CAN, WE ARE ALWAYS AVAILABLE TO ANSWER YOUR QUESTIONS.

EMERGENCY SERVICES

ALL EMERGENCY DENTAL SERVICES, OR ANY DENTAL SERVICES PERFORMED WITHIN FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIME SERVICES ARE PERFORMED.

MINOR PATIENTS

THE ADULT ACCOMPANYING A MINOR AND/ OR THE PARENTS/ GUARDIANS ARE RESPONSIBLE FOR FULL PAYMENT AND ACCEPT FINANCIAL RESPONSIBILTY FOR SERVICES RENDERED. FOR UNACCOMPANIED MINORS, NON EMERGENCY TREATMENT WILL BE DENIED UNLESS CHARGES HAVE BEEN PRE-AUTHORIZED TO AN APPROVED CREDIT PLAN, VISA/ MASTERCARD, OR CHECK AT TIME OF SERVICES HAS BEEN VERIFIED.

MISSED APPOINTMENTS

UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENT AT THE RATE OF $50.00. PLEASE HELP US TO SERVE YOU BETTER BY KEEPING SCHEDULED APPOINTMENTS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY, I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Welcome!

THE OFFICE OF **DR. P. BOSTANI**

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female……..☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated……..Age_____

Social Security #: _____ Birth Date: _____ Drivers Lic #_____

Home Address: _____
Street Apartment #

_____
City State Zip Code

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

Email:_____

Employer: _____ Occupation:_____

EmployerAddress:_____

Health Information

Do you currently have or have your ever had any of the following? Please check those that apply:

AIDS/HIV ☐yes ☐no

Allergies
- ☐ Codiene
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Metal

other_____

Anemia ☐yes ☐no
Arthritis ☐yes ☐no
Artificial Joints ☐yes ☐no
Asthma ☐yes ☐no
Blood Disease ☐yes ☐no
Cancer ☐yes ☐no
Diabetes ☐yes ☐no
Dizziness ☐yes ☐no
Epilepsy ☐yes ☐no
Excessive Bleeding ☐yes ☐no
Fainting ☐yes ☐no
Glaucoma ☐yes ☐no
Mitral valve prolapse ☐yes ☐no
Herpes / cold sores ☐yes ☐no
Head Injuries ☐yes ☐no
Heart Disease ☐yes ☐no
Heart Murmur ☐yes ☐no
☐ Hepatitis type_____
High Blood Pressure ☐yes ☐no
Jaundice ☐yes ☐no
Kidney Disease ☐yes ☐no
Liver Disease ☐yes ☐no
Mental Disorders ☐yes ☐no
Nervous Disorders ☐yes ☐no
Pacemaker ☐yes ☐no
☐ **Pregnancy**
Due date:_____
Radiation Treatment ☐yes ☐no
Respiratory Problems ☐yes ☐no
Rheumatic Fever ☐yes ☐no
Swollen neck glands ☐yes ☐no
Sinus Problems ☐yes ☐no
Stomach Problems ☐yes ☐no
Stroke ☐yes ☐no
☐ Smoke How much_____
☐ Tumors type_____
Ulcers ☐yes ☐no
Venereal Disease ☐yes ☐no
Psychiatric care/meds ☐yes ☐no
Low blood pressure ☐yes ☐no
Chemical dependency ☐yes ☐no
Tuberculosis ☐yes ☐no
OTHER:
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list any medications you are currently on (including birth control): _____
  _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you wear a cardiac pacemaker, or have you had Heart Surgery ☐ Yes ☐ No
- Have you ever taken any of the group of drugs collectively known as "fen-phen" (fen-phen diet)? These include Ionimin, Adipex, Fastin, Pondimin, and Redux. ☐ Yes ☐ No
- Have you ever taken any medications for *OSTEOPOROSIS* collectively known as Phosphonates for increasing bone density? These include Fosamax, Zomeda, Aredia, Boniva, Actone ☐ Yes ☐ No
- Do you need to be pre-medicated with antibiotics before dental treatment ☐ Yes ☐ No Reason?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Doctor Review Date_____ Signature_____

Dental History

Please check all that apply:

Bad breath ☐yes ☐no	Dry Mouth ☐yes ☐no	Loose teeth ☐yes ☐no	Sensitivity to cold ☐yes ☐no
Bleeding gums ☐yes ☐no	Food between teeth ☐yes ☐no	Mouth breathing ☐yes ☐no	Sensitivity to heat ☐yes ☐no
Chew on one side ☐yes ☐no	Grinding / Clenching teeth ☐yes ☐no	Orthodontic treatment ☐yes ☐no	Sensitivity to sweets ☐yes ☐no
Cigarette or Cigar ☐yes ☐no	Gums swollen, tender ☐yes ☐no	Orthodontic retainers ☐yes ☐no	Sensitivity when biting ☐yes ☐no
Clicking jaw ☐yes ☐no	Lip, cheek biting ☐yes ☐no	Periodontal treatment ☐yes ☐no	Sores or growths ☐yes ☐no

Additional Information

Spouse / Parent Name:_____ Phone number:_____

Spouse / Parent Employed by:_____ Occupation_____

Spouse / Parent Social Security #_____ Spouse/Parent Birth date_____

Who is responsible for this account:_____Relation to patient:_____

In case of an emergency, contact:_____Phone_____

Insurance Information

Primary Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insurance Company:_____

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

Secondary Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insurance Company:_____

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

Assignment and Release

ASSIGNMENT

I, the undersigned, have insurance with_____, and assign directly to Dr. Payam Bostani all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

⊗**DATE**_____ ⊗**SIGNATURE**_____

MINOR / CHILD CONSENT

I, being the parent or guardian of _____, do hereby request and aouthorize the dental staff to perform the necessary dental services for my child, including but not limited to x-rays, and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

⊗**DATE**_____ ⊗**SIGNATURE**_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents / guardians are responsible for all fees and services rendered for treatment of a minor / child. I accept full financial responsibility for all charges not covered by insurance.

⊗**DATE**_____ ⊗**SIGNATURE**_____

MEDICAL UPDATE (to be filled out at future appointments)

Has there been any change in your health since your last dental appointment? ☐yes ☐no
If yes, please specify:_____
Are you taking any new medications? ☐yes ☐no If so, what?_____

Patient's Signature_____ DATE_____