Justin L. Morrison, DDS

GENERAL FAMILY DENTISTRY

Today's Date: _____

Mr/Miss/Mrs/Dr Patient's name _____ Preferred name _____

If minor, parents/guardian names:_____

Home phone _____ Work phone_____ Cell phone_____

Email:_____

Changes in Mailing Address: Yes / No If yes: New Address: _____

Changes in Dental Insurance: Yes / No If yes:_____ Changes in Employer: Yes / No

Family Physician: _____ Pharmacy/location: _____

Are there any **NEW** allergies that you have developed? Yes/No

List Any Medications You Are Currently Taking:

- ❑ Antibiotics
- ❑ Insulin
- ❑ Anticoagulants
- ❑ Muscle Relaxants
- ❑ Barbituates
- ❑ Blood Thinners
- ❑ Pain Medication
- ❑ Codeine
- ❑ Sleeping Pills
- ❑ Cortisone
- ❑ Sulfa Drugs
- ❑ Ginko Biloba
- ❑ Diet Pills
- ❑ Heart Medication
- ❑ Tranquilizers
- ❑ Medications for Osteoporosis
- ❑ Bisphosphonates (Fen Phen, Fosamax, Boniva, etc)
- ❑ Herbal Supplements
- ❑ Other: _____ _____
- ❑ None

Please list any **NEW** and/or **CHANGES** in current medications with dosages since your last dental visit:

_____

_____

_____

Please list other healthcare practitioners seen within the last year:

Practitioner Specialty Treatment and Approx Date

_____

_____

_____

_____

Any surgeries in the last year: Yes or No. If yes, please list below:

_____

_____

_____

Do you take aspirin regularly: Yes or No

Do you smoke or chew tobacco: Yes or No. If yes, how much on a daily basis: _____

Are there any changes to your medical history that we need to be aware of? Yes / No Please explain to us if yes.

Or has anything changed in your health status in the past year? Yes / No Please explain to us if yes.

Women: Are you currently pregnant or trying to get pregnant? Yes or No

Patient Signature X_____

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BECAUSE MUTUAL UNDERSTANDING IS THE BASIS FOR GOOD RELATIONSHIPS, IT IS IMPORTANT FOR YOU TO UNDERSTAND THE NATURE OF OUR OFFICE POLICIES RELATED TO APPOINTMENTS. THESE ARE DETAILED BELOW.

Cancellation/ Appointment Policy

Thank you for choosing us as your dental health care provider. We believe all patients deserve the very best dental care we can provide so all of our appointments are reserved for you and for you alone per each provider in our office.

INITIAL:

_____ Appointments are by appointment only, we **do not** treat walk in patients, but we do understand that emergencies happen. If you have what you feel is a true dental emergency, please contact us as soon as possible, so that we can give you our first available time to see you. In cases of emergencies, we will do our best to work you into the schedule as soon as possible.

When appropriate, we prefer to schedule longer and fewer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

_____ Our staff makes every effort to be on time for our patient's appointments and we ask that you extend the same courtesy to us. **If you are 15 minutes late for your appointment you may be asked to reschedule your appointment.**

Like many offices, this office does call to confirm your appointment and/or send text messages. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. The automated text service will notify you of your upcoming appointments. To confirm the appointment, please simply follow the text instructions. This usually means to simply reply with a "C". Please keep in mind that if you do not reply "C" the automated system will not register it as a confirmation, and may continue to send you more texts to ensure you remember your reserved appointment.

We know that patients are busy, and we try to not disturb them with multiple reminder calls. However, if we do not receive a reply through the automated texting service, we will attempt to contact you two business days prior to your appointment, at the telephone number you designated on your paperwork.

_____ If every attempt has been made to contact you and you don't respond to us, we may either send a text or leave a voicemail stating that if the appointment is not confirmed by 48 hours in advance the appointment will be cancelled so that we may treat another patient.

_____ **There will be a charge of $25 per 30 minutes ($50 per hour) of scheduled time for a broken appointment or cancellation with less than 48 hours' notice for your appointment.** If we are successful in filling your appointment time with another patient, there will be no broken appointment charge. Messages and electronic correspondence will be considered as notice, unless it is done after the requested time, then it will not be considered adequate notice and the fee will apply.

_____ If there is a repeated history of no show/cancellations, you will be asked to pre-pay in full for your appointment at the time of scheduling.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

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Treatment "Warranty"

The "warranty" provided by Dr. Morrison is as follows:

In order for Dr. Morrison to stand by his treatment, we require that you maintain your professional teeth cleaning appointments every 3, 4, or 6 months as recommended by Dr Morrison and his team, as this allows us to monitor and maintain your dental work. Also, your account must be in good standing, including fees incurred for failed or broken appointments. Failure to do so may result in a patient's financial responsibility if treatment fails. All warranty replacements are at the discretion of Dr. Morrison.

By signing below, I acknowledge that I understand the above.

_____ _____

Patient Date

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Medicare Opt Out Form:

This contract is between Justin L. Morrison, DDS ("Dentist") and Patient or Patient's legal representative listed below (Medicare beneficiary, referred to in this contract as "Patient"). Justin L. Morrison, DDS has elected to opt out of Medicare. A dentist who opts out is not required to submit claims on behalf of beneficiaries and is not subject to Medicare limits on charges for covered services.

1. Justin L. Morrison, DDS represents that he "is" excluded from participation under the Medicare program under 1128, 1156 or 1892 of the Social Security Act.
2. Patient (or Patient's legal representative) and Justin L . Morrison, DDS agree that Patient is not now facing an emergency or urgent health care situation.
3. By signing this contract, Patient (or Patient's legal representative) does the following:
    a) Accepts full responsibility for payment of Dentist's charge for all services furnished by Dentist;
    b) Understands that Medicare limits do not apply to what that Dentist may charge for items or services furnished by the Dentist;
    c) Agrees not to submit a claim to Medicare or to ask Dentist to submit a claim to Medicare;
    d) Understands that Medicare payment will not be made for any items or services furnished by Dentist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
    e) Enters into this contract with the knowledge that Patient has the right to obtain Medicare covered items and services from dentist, physicians, and practitioners who have not opted out of Medicare, and that Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other dentists, physicians, or practitioners who have not opted out;
    f) Understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;
4. This form will have to be signed every 2 years by the patient, as required by Medicare.

This contract shall remain in force and effect from the date it is signed by the Patient until the end of the term of the Dentist's current opt-out period.

Patient Name: _____ Date: _____

Patient Signature: _____

*This form is to inform that we are **not** a Medicare provider. Please sign acknowledging that you understand that we do not file to Medicare (even though you may not have Medicare).

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Our Office Financial Policy

We believe that everyone benefits when specific financial arrangements are understood and agreed upon up front. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, DEBIT CARDS, CHECKS, VISA, MASTERCARD, AND DISCOVER CREDIT CARDS. WE ALSO OFFER **CARE CREDIT & Lending Club** WHICH ARE EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL.

INITAL

_____ Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when we call to confirm your appointment.

_____ The adult accompanying a **minor** and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will not be completed unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified. Consent for treatment will also need to be pre-approved or verbal consent in case of an emergency. (Treatment consent must be signed and payment arrangements made in advance to treating unaccompanied minors)

Regarding Insurance

_____ We cannot bill your insurance unless you call or bring in all insurance information prior to your dental visit. If we have all of your insurance information prior to your appointment, we will be happy to file your dental claim as a courtesy to you. We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided.

_____ PLEASE UNDERSTAND that we file your dental claim as a courtesy to our patients. Your insurance policy is a contract between you and your insurance company. We are not responsible for how your insurance handles its claims or for what benefits they pay on a claim. We can only assist you in ESTIMATING your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. Please be aware some and possibly all of the services provided may not be covered services and not considered reasonable, usual, and customary under the terms of your dental policy.

_____ You are responsible for any balance on your account after 60 days, whether your insurance company has paid or not. We will be glad to send a refund if your insurance company does end up paying. If there is an outstanding balance on the account for more than 60 days, you and other family members will not be able to receive treatment until balance is paid in full.

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.

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Payment Plans

_____ Justin L. Morrison DDS has partnered with Care Credit & Lending Club, patient financing companies, to offer our patients 0% interest financing for 6 months with approval. No other payment plans are available.

Pre-Payment

_____ ALL Treatment with Dr. Morrison & certain procedures with hygienists require a pre-payment deposit of at least $50 for treatment; this is to be paid in advance when scheduling your appointment. If the patient no shows the appointment or cancels with less than 48 hour notice the pre-payment will be non-refundable, and another $50 pre-payment deposit is required to reschedule.

Billing

_____ If there is a balance on the account after insurance has paid we will send a statement in the mail- payment is due upon receipt. There is a $30 returned check fee.

Refunds

_____ Refunds for overpayment will be sent after all treatment is completed and insurance has been collected on all of your family members.

Collections

_____ Any account that has not received a minimum payment of at least 20% of the balance within 90 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

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

Printed Name: _____

Signature: _____

Date: _____

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Dental Insurance/Patient Information and Financial Policy

INITIAL

_____ Insurance coverage will be verified on your first visit and we are happy to file your dental insurance for you. Please remember that the information that we receive from your insurance carrier is never a guarantee of payment and nothing is final until full payment in received. **WE CAN ONLY ESTIMATE WHAT YOUR INSURANCE WILL PAY**.

_____ **Please note that you are fully responsible for understanding your insurance benefits and you are financially responsible for any denied or unpaid claims/services incurred at our office.**

_____ **Please remember to update our office of any changes to your health history, allergies, medications, and insurance benefits PRIOR TO THE BEGINNING OF YOUR APPOINTMENT.**

We understand the importance of utilizing your dental benefits to the maximum to keep out of pocket expenses to a minimum for our patients, families, and friends. We strive for excellence in our practice and hope that patients understand that the "does my insurance cover it" question is valid. As a reminder, your insurance company will make the ultimate decision on what they choose to cover or not to cover once they receive a dental claim from our office. This does not mean that your dental insurance company can dictate the needs for your dental care, when you are seeing Dr. Morrison. Insurance is meant to help/assist with your out of pocket expenses, not to dictate what treatment is completed, needed, and recommended.

We pride ourselves on our ability to estimate your patient share/co-pay and insurance share with a high accuracy rate. However, please understand that this is only an estimate.


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