NEW PATIENT PAPERWORK CHECKLIST

Thank you for taking the time to visit our website and for downloading your new patient paperwork. In order for your appointment to begin on time, please review the following checklist and bring each of the items listed on it with you to your appointment. If you need directions to our office, you can either visit our website or call us directly. We are here to help!

- ☐ Picture ID (driver's license or other government issued identification card with photograph).
- ☐ Dental Insurance Card (without this card, we will not be able to file your insurance claim).
- ☐ Completed New Patient Registration Form (please fill out **ALL** applicable portions including social security number and date of birth).
    - Also, please fill out your email address and cell phone number as this is how we will confirm your appointments. We will use these items ONLY for getting in touch with you regarding your dental appointments and general care.
- ☐ Completed Medical and Dental Health History Form (please be thorough).
- ☐ Signed HIPAA/Assignment of Benefits form.
- ☐ Signed Financial and Office Policy form (if a minor, signature needs to be by the person who is financially responsible for patient).
- ☐ A form of payment (we accept all major credit cards as well as personal checks and cash).

We look forward to meeting you soon! If you have any questions regarding your new patient paperwork or have questions about anything else regarding your appointment or your teeth, don't hesitate to call our office. If you find that you cannot arrive for your appointment on time, please make sure to give our office **at least 48 hour** notice.

Sean P. Cooney, DMD

636-349-0070

Revised 10/16/2017

OFFICE, FINANCIAL AND PATIENT POLICIES

Patient Acknowledgements, Agreements and Authorizations

Sean P. Cooney, DMD, LLC is committed to providing all patients with exceptional service and care. Please read the following carefully as it outlines important information about patient obligations at our office.

Treatment Plan Estimates: Sean P. Cooney, DMD, LLC prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to Sean P. Cooney, DMD, LLC when the estimate is made. As your treatment progresses, Dr. Cooney may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. It is an **estimate** and your insurance benefits may be higher or lower than estimated. Please understand that your dental insurance contract is between you or your employer and the dental insurance company. Our office is only a provider of treatment and has no authority over the insurance company in decisions of payment or non-payment of claims. **We file your insurance claims as a courtesy** to you and in the event that your insurance denies a treatment already completed or in the process of being completed, you, in all cases, are responsible for amounts not covered by your insurance. In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

Refund Policy: All refunds will be made by check and mailed to the original payor. Any refund of payment originated through third party lenders must be refunded to the original account. Please contact the third party lender for more information regarding their refund policy. Upon receipt of a request for a refund, Sean P. Cooney, DMD, LLC will confirm all patient and insurance payments have cleared the bank (this may take 15 business days or longer). Once the credit balance is confirmed, Sean P. Cooney, DMD, LLC will issue a refund check within 10 business days.

Appointment Policy: Each appointment time we give for your treatment is reserved just for you. Please understand that we have many patients wanting to be seen and that failure to keep your scheduled appointment means not only inconveniences to our office, but to other patients with needed treatment. If our office does not receive **at least a 48 hour notice** you may be given an appointment on a last minute basis. Missed appointments will be subject to a fee of at least $50 for minor treatment and $100 for major treatment. This fee is applied to payment of staffing and facility costs for your missed appointment.

Our office schedules an appropriate amount of time for each appointment. In consideration for our other patients, it is important that you arrive on time, if not early, for your appointment. Patients who arrive more than 15 minutes late for their appointment may be rescheduled for treatment.

We strive to maintain a safe environment for our patients and we do not allow children or other family members in the operatory during an appointment. In addition, children under the age of 10 are not permitted in the waiting area unsupervised. Unruly children will not be permitted to remain in the office for any reason.

Payment and Financial Policy: Payment for major treatment is due **before** treatment is scheduled. Payment for all other treatment will be due at the time of service

Patients are **always** responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law. Our office receives **limited** knowledge of your specific dental coverage from the dental insurance company and while we use our best efforts to work within the exclusions of your specific plan, our first priority is the diagnosis and treatment of your dental issues in a conservative manner consistent with the **standard of care**. We will do our best to prepare you for any additional financial responsibility, but ultimately, **the responsibility of knowing your insurance coverage lies with you**, the patient.

Sometimes, it becomes necessary for you to complete additional paperwork and/or contact your employer or insurance company directly in order for your insurance claim to be processed and paid. If you do not take the required steps to have your claim processed or your insurance company has not processed and paid the claim within forty-five (45) days from the filing date, you, the patient, will be responsible for the entire balance of your treatment.

There will be a $25.00 charge for each returned check and a $15.00 minimum charge for transfer of records from our office.

Overdue Accounts: Any balance that remains on your account over 90 days will be sent to a collection agency and/or attorney for processing and will incur a 1.5% interest charge per month for each month the balance exists. **Collection action may negatively impact your credit rating**. You will be responsible for all fees associated with the recovery of overdue payments from a collection agency as follows

- Accounts under 1 (one) year old will incur an additional 33% of the balance due
- Accounts between 1 (one) and 5 (five) years old will incur an additional 40% of the original balance due
- Accounts over 5 (five) years old will incur an additional 50% of the original balance due.

In the event that it becomes necessary for the doctor to employ legal counsel and/or initiate litigation to recover any sums as a result of services provided to the patient, the doctor shall be entitled to recover an additional 33% of the original amount due (plus interest as stated above) plus court costs incurred in such action (a minimum of $175). The patient agrees that the venue for any litigation required to recover money for services rendered shall be in St. Louis County, Missouri.

Dual Insurance: If you carry dual insurance coverage, the following may apply to you.

- Dual insurance benefit levels are determined solely at the discretion of the insurance companies. All out of pocket expenses are estimated on the front end and are calculated after the claim has been processed by your explanation of benefits paperwork. Our office does not set fees or benefits amounts.
- Our office reserves the right to demand payment in full at the beginning of treatment if either or both insurance companies have a track record of tardy payments.
- Regardless of your insurance coverage, the responsibility for treatment costs lie solely with you.
- If you no longer have dual insurance coverage, the responsibility to inform the remaining insurance company of this lies with you. You have 14 days from the date of your first treatment to inform the insurance company before the full amount becomes your responsibility.
- **If your account comes due and is not paid in a timely manner, your account will either be turned over to a collection agency or to an attorney for collection.**

FSA/HSA or other Expense Accounts: Upon request, our office will provide you with an itemized statement of your dental treatment for FSA/HSA purposes. Your FSA/HSA may, at their sole discretion, freeze your account until they have completed a full accounting of your dental treatment. Our office does not and will not have any contact with your expense account administrator and has no control over what action they take on your account(s). Our office assumes no liability for adverse events pertaining to your FSA/HSA account(s). Any time spent by our office staff beyond providing you with an itemized statement will incur a minimum charge of $25 per occurrence.

Treatment Options: Dr. Cooney operates a metal free practice. All crowns and fillings are tooth colored. These options are scientifically proven to be better for your teeth in the long term. Your insurance company may only cover metal fillings and crowns. In most cases, these metal only options result in a lower reimbursement by your insurance company and additional out of pocket expense for you. If you have questions for regarding your filling and crown options, please ask Dr. Cooney prior to your treatment.

We may change this policy from time to time without prior written notice. Our most recent policy sheet is available for review.

PATIENT, PARENT, OR GUARDIAN SIGNATURE _____ DATE:__ _____

Revised 10/16/2017

HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment
- Obtaining payment from third party payers (e.g. my insurance company)
- **Discussions of treatment and payment with the person(s) listed below:**
  - _____
  - _____

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We may change this policy from time to time without prior written notice. Our most recent policy sheet is available for review.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

ASSIGNMENT OF BENEFITS

I understand that services rendered to me by Dr. Cooney are my financial responsibility and that the Provider will bill my insurance company, **as a courtesy**. I authorize my insurance company to pay my benefits directly to Sean P. Cooney, DMD, LLC and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will forward the payment to Sean P. Cooney, DMD within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

PATIENT REGISTRATION FORM

Patient Information (please fill out **ALL** of this section)

Last Name:_____ First Name_____ Middle Initial:_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone:_____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Whom may we thank for referring you to us? ☐ Phone Book ☐ Website ☐ Insurance Individual_____

Under 18 (please fill out all information in this section **only** if the patient is under 18 years of age)

Mother's Name _____ Soc Sec:_____

Father's Name _____ Soc Sec: _____

Appointment Confirmation (please provide both)

Email address: _____

Cell Phone: _____

WE WILL ONLY USE THESE FORMS OF COMMUNICATION TO CONTACT YOU ABOUT YOUR DENTAL CARE AND APPOINTMENTS

Primary Dental Insurance Information (if applicable)

Name of Insured: _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐ Other

Address of Insured (if different from above): _____

Soc Sec of Insured*: _____ _____ _____ Birth Date of Insured: _____

Employer: _____ Phone: _____

Insurance Co: _____ Address: _____

City/State/Zip: _____

Member ID:_____ Group Number:_____

Emergency Information

Emergency Contact: _____

Emergency Contact Telephone: _____

Pharmacy Name: _____

Pharmacy Telephone: _____

Physicians Information

Physicians Name: _____ Physicians Telephone: _____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this form authorizes my dentist to submit claims for benefits and/or services rendered (or to be rendered) without obtaining my signature. This holds true for myself and/or my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I also acknowledge that I will be personally responsible for any and all charges not covered by my insurance.

PATIENT, PARENT, OR GUARDIAN SIGNATURE _____ DATE : _____

MEDICAL AND DENTAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No
Are you currently under the care of a physician?	☐ Yes	☐ No
Has there been a change in your health within the past two years?	☐ Yes	☐ No
Have you ever had a serious head, neck, or jaw injury?	☐ Yes	☐ No
Are you currently taking prescription drugs	☐ Yes	☐ No
Are you currently taking non-prescription drugs?	☐ Yes	☐ No
Have you ever been given medications or injections for osteoporosis?	☐ Yes	☐ No
Have you ever had an allergic reaction in the dental office?	☐ Yes	☐ No
Have you ever been diagnosed with periodontal/gum disease?	☐ Yes	☐ No

When was your last dental cleaning? _____

Do you use tobacco? ☐ Yes ☐ No If yes, how much? _____

WOMEN: ARE YOU?

- Pregnant/Trying to get pregnant? ☐
- Taking Oral Contraceptives? ☐
- Nursing? ☐
- Taking Hormone Replacements? ☐

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin ☐ Codeine ☐ Latex ☐ Metal ☐ Penicillin ☐ Local Anesthesia ☐ Other: _____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
AIDS/HIV positive	☐	☐	Emphysema/COPD	☐	☐	Pacemaker	☐	☐
Alzheimer's Disease	☐	☐	Epilepsy/Seizures	☐	☐	Psychiatric Care	☐	☐
Anaphylaxis	☐	☐	Excessive Thirst	☐	☐	Parkinson's Disease	☐	☐
Arthritis/Gout	☐	☐	Eye Problems	☐	☐	Recent Weight Loss	☐	☐
Artificial Joint	☐	☐	Fainting Spells/Dizziness	☐	☐	Rheumatoid Arthritis	☐	☐
Artificial Heart Valve	☐	☐	Frequent Headaches	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Heart Disease/Failure/Attack	☐	☐	Sinus Trouble	☐	☐
Blood Disorders/Anemia	☐	☐	Hepatitis A, B, or C	☐	☐	Stomach/Intestinal Disease	☐	☐
Bruise Easily	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Hives or Rash	☐	☐	Swelling of Limbs	☐	☐
Chemotherapy/Radiation	☐	☐	Hormonal Problems	☐	☐	Thyroid Disease	☐	☐
Chest Pains/Angina	☐	☐	Hypoglycemia	☐	☐	Tonsillitis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Kidney Problems/Dialysis	☐	☐	Tuberculosis	☐	☐
Convulsions	☐	☐	Liver Disease	☐	☐	Tumors or Growths	☐	☐
Diabetes	☐	☐	Lung Problems	☐	☐	Ulcers	☐	☐
Drug/Alcohol Addiction	☐	☐	Osteoporosis	☐	☐	Venereal Disease	☐	☐

Has anyone in your family ever had any of the medical issues listed above? _____

Have you had any serious illness not listed above? _____

Is there anything you wish to tell us that has not been asked? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status, including changes in medications prescribed or not prescribed by my (or patient's) physician. I have understood each item on this form and have been given the opportunity to ask questions regarding them.

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

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