Geneva Family Dentistry
Jonathan D. Markham, D.M.D.
Robert R. Rowell, D.M.D.

Patient Information

Patient Name: _____ Preferred Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: _____ Sex: _____ Dental Insurance: Yes__ No___

Address: _____

Responsible Party (if other than the patient): _____ Relationship to patient:_____

Cell Phone #: _____ **May we contact you via: Text? Yes ___ No___ Email? Yes ___ No___**

Home Phone #: _____ Email Address: _____

Work Phone #: _____ Employer: _____

Secondary Contact (name and phone #):_____

How did you hear about our office?_____

Acknowledgement of Receipt of Notice of Privacy Practices

Note: you may refuse to sign this form

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Guardian:_____Date:_____

Consent for Use and Disclosure of Health Information / Electronic Communication

We respect our legal obligation to keep health information that identifies you private. We may use and disclose your health information for different purposes, including treatment, payment, and health care operations (See Notice of Privacy Practices). For example,

* We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment.
* We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.
* We may need to use your personal information to remind you of your appointments and send you a reminder card.

Sometimes our practice needs to send protected health information to you or someone else (such as a provider) via electronic means. This may include transactions such as unencrypted email. We strive to keep all patient information secure; unfortunately, there is no assurance of confidentiality of information when communicating this way. If you are concerned about the security of your protected health information that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver. If you don't sign this form, this office may use other ways to send your information, such as U.S. Mail, or may ask you to send your information to third parties yourself.

By signing below, I consent for use and disclosure of health information AND for unencrypted electronic communication.

Signature of Patient/Guardian:_____Date:_____

Geneva Family Dentistry: Financial Agreement/Consent for Treatment

Patient Name: _____

Financial Agreement

We strive to keep dental costs affordable, and we make every effort to advise you of your estimated financial responsibility. If you have any questions about treatment or financial estimates, please notify a staff member promptly.

Payments: **All payments and deductibles are due at time of service.** We accept cash, check, credit/debit card, and Care Credit. I understand that if my account becomes delinquent it may be placed with an attorney or collections agency. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1.5% per month (18% per annum); (2) I agree and hereby consent that I will be responsible for reasonable collection costs and attorney's fees in the amount of 33 1/3 %, in addition to the outstanding balance, and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Geneva County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive all rights to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided, I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida, I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy, I understand my credit history will be investigated and thoroughly reviewed.

Insurance: If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is your responsibility. Our office accepts payments from most major dental insurances. If your insurance does not cover 100 percent of the charges, you may be billed any additional amount. Regardless of insurance, you are responsible for your account.

Cancellation/No Show Policy: Our office requires a 24-hour notice for any cancelled appointment. A cancellation fee may be assessed for canceling an appointment without 24-hour notice or not showing up for an appointment. The cancellation fees are as follows:

- $50 for all appointments booked with a dental hygienist
- $75 for an appointment booked with a doctor

Reservation Deposit: Our office requires a reservation deposit for appointments 1 hour and 45 minutes or longer booked with the doctor. This deposit will go towards the treatment and is fully refundable IF cancellation or appointment changes are made prior to 24 hours before the appointment. If a 24-hour notice is not given, then the cancellation fee will be assessed from the deposit.

Treatment Estimates: Our office strives to give the closest estimate of financial responsibility based on pre-planned treatment by the doctor. If you have dental insurance, it may have exclusions, limitations, or other conditions that are not known by our office or are not calculated in the estimate. If you would like more insurance information, we recommend that you contact your insurance company for specific coverage information that may be available to you. We may also be able to submit a pre-treatment estimate to your insurance company. Feel free to request this service. If available, it usually takes 2-4 weeks.

Consent for Treatment

I consent and authorize Dr. Markham, Dr. Rowell, and/or staff to render current and future dental services that may be indicated for my own dental health. These services include but may not be limited to: extractions, radiographs, oral surgical procedures, periodontal therapy, operative dentistry, cosmetic dentistry, fabrication of prosthetics, endodontic treatment, dental cleanings, exams, and the use of local anesthetics. I assume the right and responsibility to ask for any risks of treatment, alternative treatment, as well as the financial responsibility for the treatment. I authorize the doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my needs. I understand that I may decline any treatment proposed. By signing below, I acknowledge and understand that the practice of dentistry is not an exact science and has many inherent risks that include but are not limited to: precipitation of medical emergencies, reactions to medications and anesthetics, bleeding, infection, damage to adjacent teeth or dental restorations, permanent or temporary numbness, or unsuccessful treatment. I acknowledge that I assume these risks when undergoing dental treatment.

By signing below, I acknowledge that I understand this office's Financial Agreement AND I consent for treatment as stated above.

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Signature of Patient/Guardian