KOCHEVAR ENDODONTICS

FINANCIAL AND INSURANCE POLICY

THE FACTS

- Please understand we are desirous to extend care to you and work with you and any insurance coverage you may have. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
- For your convenience we will estimate the portion of your total fee that your dental insurance company will cover. This is just an estimate. After insurance benefits, you are responsible for any unpaid balance. We will ask you to bring the estimated uncovered portion of the total fees to be paid at the time of treatment.
- If you desire to know exactly what your insurance coverage will be, prior to treatment, then we can predetermine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.
- Our policy requires a percentage of the fee to be paid at time of treatment if patient has Dental Insurance. Payment options include: Cash | Check | Major Credit Cards | Care Credit. Full payment is required at time of treatment, if there are no insurance providers or if there have been no payment arrangements made with Kochevar Endodontics.
- Unfortunately, trends show that insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agrement allows. You however are entitled to discuss employee benefits with your employer and make recommendations for change for a more competitive policy and provider.
- All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum) after 60 days. In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.
- You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device as applicable.

I/We have read this disclosure and agree to terms listed above.

PATIENT NAME (PLEASE PRINT) SIGNATURE DATE

HIPAA CONSENT

- **PURPOSE OF CONSENT |** By signing this form, you will consent to our use and disclosure or your protected health information to carry out treatment, payment activities and healthcare operations.
- **NOTICE OF PRIVACY PRACTICE |** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
- **RIGHT TO REVOKE |** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not effect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Michelle Beaves | 801-282-1651 work | 801-253-4320 fax | michelle.kochevarendo@gmail.com

- **SIGNATURE |** I, _____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

PATIENT NAME (PLEASE PRINT) SIGNATURE DATE

Revised 05/2020

KOCHEVAR ENDODONTICS

PATIENT INFORMATION

PATIENT INTRODUCTION - *Please print*

PATIENTS FIRST NAME	MIDDLE NAME	LAST NAME	GENERAL DENTIST
SOCIAL SECURITY	DATE OF BIRTH	SEX	MARITAL STATUS
EMAIL ADDRESS		CELL PHONE	HOME PHONE
MAILING ADDRESS		APT CITY	STATE ZIPCODE
PATIENT'S OCCUPATION	PATIENTS EMPLOYER	WORK PHONE	WORK EMAIL
SPOUSES NAME	SPOUSES EMPLOYER	SPOUSE'S DATE OF BIRTH	SPOUSE'S PHONE

WHO WERE YOU REFERRED BY: ☐ FAMILY OR FRIEND ☐REFERRING DENTIST _____ ☐ YOUR INSURANCE ☐ INTERNET

RESPONSIBLE PARTY - *If not the same as above - Please print*

FIRST NAME	MIDDLE NAME	LAST NAME	HOME PHONE
MAILING ADDRESS		APT CITY	STATE ZIPCODE
RELATIONSHIP TO PATIENT	EMPLOYER	WORK PHONE	EMAIL ADDRESS

DENTAL INSURANCE INFORMATION - *Please print*

PRIMARY INSURANCE COMPANY	INSURANCE ADDRESS		EMPLOYER
POLICY HOLDER (SUBSCRIBER)	DATE OF BIRTH	ID#	GROUP #
SECONDARY INSURANCE COMPANY	INSURANCE ADDRESS		EMPLOYER
POLICY HOLDER (SUBSCRIBER)	DATE OF BIRTH	ID#	GROUP #

SPECIAL REQUESTS

I have been given the opportunity to ask any questions and have received answers to my satisfaction _____INITIAL/ DATE

KOCHEVAR ENDODONTICS

PATIENT INFORMATION

HEALTH INFORMATION - *The following confidential information is for our records only*

Are you in good health?	Yes	No
Have you been hospitalized within the past 2 years?	Yes	No
Are you currently under medical care?	Yes	No

IF YES, FOR WHAT REASON

Are you currently taking any medication?	Yes	No

IF YES, LIST MEDICATIONS

Are you allergic to any drugs?	Yes	No

IF YES, LIST MEDICATIONS

Are you allergic to latex	Yes	No
Do you require antibiotic pre-medication prior to dental treatment?	Yes	No
Do you have an unfavorable reaction to dental treatment?	Yes	No

IF YES, FOR WHAT REASON

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD - *The following confidential information is for our records only*

- ANEMIA / BLOOD DISORDER
- ARTHRITIS
- ARTIFICIAL JOINTS OR VALVES
- ASTHMA
- BLEEDING PROBLEMS
- CANCER
- DIABETES
- EXCESSIVE BLEEDING
- EPILEPSY
- HEART PROBLEMS
- HEPATITIS
- HERPES
- HIGH BLOOD PRESSURE
- H.I.V +
- KIDNEY PROBLEMS
- OSTEOPOROSES / OSTEOPERIA
- RHEUMATIC FEVER
- STROKE
- TUBERCULOSIS

FEMALE PATIENTS - *The following confidential information is for our records only*

Are you pregnant?	Yes	No

IF YES, WHEN ARE YOU DUE

SPECIAL REQUESTS

I have been given the opportunity to ask any questions and have received answers to my satisfaction _____INITIAL/ DATE