



DAVID H. DOGGETT BORDEAUX, D.D.S., M.A.G.D.

Dentistry for Midtown • 855 Juniper Street NE, Atlanta, Georgia 30308

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT INFORMATION

Please fill out form and mark fields that do not apply to you as NA.

Full Name _____ SS# _____ Date _____

Mr. Ms. Dr. Mrs. Miss

Nickname: _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____

Business Phone # _____

Cell Phone # _____

Birthday _____

Married Single Divorced Widowed Partner

Spouse _____

E-mail Address _____

For Dependent Patient Or / Child Dependent
Child Patient _____
Child's address, if different: _____ _____
Home Phone # _____
Birthday _____ Age _____ Grade _____
School _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____

Driver's license # _____

Bank _____

Your Spouse _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Business Address _____

Business Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Business Phone # _____ Ext. _____

Business Phone # _____ Ext. _____

DENTAL INSURANCE

PRIMARY CARRIER _____ **EMPLOYER** _____

Social Security # _____

Group # _____

Insurance Co. _____

Date employed _____

Employee _____

800 # _____

SECOND CARRIER - We do not file secondary insurance but will be glad to provide you with all paper work necessary.

GETTING TO KNOW YOU

Is another member of your family, or relative, a patient at our office? _____

Who referred you to us? _____

Minor children and ages _____

Person to contact in an emergency _____ Phone # _____

Address _____

Closest relative not living with you _____ Phone # _____

Address _____



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Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used by us in any form are kept confidential.

As our patient we want you to know that we respect the privacy of your personal medical/financial records and will do all we can to secure and protect that privacy. Our staff is trained to release only the minimum information to only those in need of your healthcare information regarding *treatment, payment, or healthcare operations*, in order to provide healthcare that is in your best interest.

The following rights may be exercised by presenting a written request to our Privacy Officer with respect to your protected health information:

- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to obtain a copy of this notice, in its entirety, upon request
- The right to request restrictions on information for certain uses including disclosures to family members or any other person identified by you

You may refuse to consent to the use or disclosure of your personal health information - this must be done in writing. However, under this law we may also refuse to treat you as our patient, if you should refuse to disclose your personal health information.

We would like to assure you, as our highly valued patient, that we are in compliance with government rules and regulations concerning your privacy. Our practice will continually strive to comply with "HIPAA" guidelines concerning the proper disclosure of your Personal Health Information.

David H Doggett Bordeaux D.D.S., M.A.G.D.



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Notice of Privacy Practices Consent

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the practice is not required to agree to my requested restrictions; however, if the practice does agree then it is bound to abide by such restrictions.

Patient Name (please print): _____

Signature OF PATIENT: _____

Date: _____

Signature of parent or guardian: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Consent, but was unable to do so as documented below:

Date:	Initial:	Reason



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Appointment/Financial Guidelines

Appointment Cancellation or Rescheduling

Initials _____

When you schedule a dental or hygiene appointment, that time is reserved just for you. We understand that emergencies do arise and will take this into consideration; however, we require the following notification in consideration of other patients waiting to schedule appointments.

- **Dental Appointments** - 48-hour notice or a cancellation fee of \$50.00
- **Hygiene Appointments** - 48-hour notice or a cancellation fee of \$25.00

Insurance

Initials _____

This practice is not an in-network provider with any insurance company. However, you may receive out-of-network benefits and we will be glad to assist you by filing your insurance with your primary carrier. Please remember, our agreement is with you and not your insurance carrier. We have no control over the coverage you or your employer haven chosen. If your insurance information changes, it is your responsibility to notify our office of the change.

We are happy to calculate an estimate for you based on your individual insurance coverage. Please understand it is only an estimate and not a guaranteed amount of your insurance payment. The patients' estimated responsibility after insurance is due at the time of service unless other financial arrangements have been made prior to treatment. As the patient, you are ultimately responsible for total payment for services rendered regardless of insurance payment.

Your insurance claim is filed electronically within 24 hours of service. If your insurance carrier does not respond or payment is not received within 30 days, we will re-send the claim. The practice will also send any additional documentation of need as requested by insurance company. Additional follow-up with the insurance company or resubmission of claims after 90 days is the responsibility of the policy holder. It is your responsibility to contact your insurance company or pay the balance in full. You will receive a statement of account from our office each month that will show any payment(s) made by you and/or your insurance carrier. If payment is not received for the balance within 90 days after treatment and your insurance claim has been filed, finance charges will accrue at 1½% of the unpaid balance monthly.

Payment for Treatment

Initials _____

Fees for treatment are due at the time of service unless financial arrangements have been made prior to treatment. You will receive a statement of account from our office each month. This is our only means of communicating with our patients regarding the status of their account. If payment is not received within 90 days, finance charges will accrue at 1½% of the unpaid balance monthly.

If you have insurance, you are welcome to leave your credit card number on file with us for your convenience. Therefore, if there is a remaining balance after insurance, we can apply it to your card and send the receipt to you. We are pleased to accept Mastercard, Visa, American Express, and Discover. Payment to our office is neither contingent nor dependent upon your insurance company .

- Returned Check Fees - \$35.00
- Collection Fees - There is a collection fee for accounts over 120 days old.

*I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. By my signature below. I authorize said assignee to release all information necessary to secure payment from outside sources.

I acknowledge that I have read and understand all the above policies

Signature _____ Date _____

Print Name _____