zimbi
DENTAL

Welcome to Zimbi Dental!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: _____ Last Name: _____ First Name: _____

Preferred to be called: _____ Street Address: _____

City, State, Zip: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SS#: _____ Driver's License: _____ Sex: M F Married Single

Employer: _____ Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____ City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____ Place_____ Time: _____

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other _____

If you were referred whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

_____

Secondary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

(turn over page)

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have reviewed a copy of the HIPAA Notice of Privacy Practices for this office.

_____ (Date}_____
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: _____

CONSENT:

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Zimbi Dental of insurance benefits under which I am entitled.

I hereby authorize Zimbi Dental to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Zimbi Dental to make a thorough diagnosis of the patient's dental needs. I also authorize Zimbi Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

I understand that there is a $50 fee for missed appointments and appointments that are canceled without 24 hrs. notice.

So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS Ask us about EASY PAY OPTIONS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Zimbi Dental must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Zimbi Dental. I give consent for any credit check to be completed by Zimbi Dental should it be deemed necessary.**

I have read the Consent and Financial Philosophy of Zimbi Dental. I understand, accept, and agree to them.

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Witness Date