DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Shine Dental Associates of the North Shore
400 Jericho Turnpike
Syosset, NY 11791
Telephone: (516) 348-8500

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

SHINE

DENTAL ASSOCIATES OF THE NORTH SHORE
400 Jericho Turnpike Syosset, NY 11791
516-348-8500
www.ShineDentalGroup.com

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of the HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been

These are rules and restrictions on who may see or be notified of your Protected Health Information. These restrictions do not include normal exchange of information within our office. HIPPA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality of care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov
This summarizes our policy here at Shine Dental Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, insurance forms, EOB's, etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records PHI and other documentation of information.

We send our reminders to our patients. We do this by one or more of the following: e-mail, texting, calling and sending postcards. We try to make every effort possible to remind you of your appointment and any treatment that you may need. We may send out newsletters or special promotions that we are offering.

You agree to us sending electronic e-referrals to specialists, which include you PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which submitting PHI to receive payment for services provided.
You give us permission to remind you take pre-medication prior to appointments, if applicable.
You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.
The practice utilizes a number of vendors in conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
You agree to bring ay concerns or complains regarding privacy to the attention of the office manager or the doctor and understand that you have a right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.
Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services with your permission.
We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.
By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future updates to this policy.

Signature: _____ Print Name: _____

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FINANCIAL AGREEMENT

PAYMENT IS DUE AT TIME OF SERVICE
All financial arrangements are to be made before any treatment is provided.
Patient responsibility is collected on day of treatment.
***Shine Dental Associates will also be referred to as SDA in this agreement**

- PAYMENT: We accept cash, check debit/credit (Visa, Mastercard, American Express, Discover). We also accept Care Credit, Wells Fargo, and Lending Club (healthcare credit platforms). Prior to appointments, if needed, arrangements with your choice of patient financing is required. All patient financial responsibility is due at dental appointment. Only cash or credit card payments are accepted for emergency treatment. All refunds will be given in check format, in spite of the original form of payment. Refunds from third party financing companies will be refunded to the issuing bank, and the bank will then refund your account.

-FINANCE CHARGES: 1.33% per month (annual percentage rate of 16%) of unpaid balance will be added monthly.Third party financing refunds will be completed by the end of the calendar month in which they are requested. Refunds are handled with both a third party financing company and SDA. From here, the third party financing company will contact the patient and remit the appropriate refund. The patient takes responsibility for finance charges incurred by the SDA when the refund is processed. Should patient request a refund during treatment, such refund will only be processed in the amount equal to the difference between the total cost of completed treatment, rendered services, special part orders and the full cost of the allotted treatment plan. Patient becomes responsible for x-rays and imaging fees (panoramic x-rays, CT's, etc.) if they are taken during the initial consult, and the patient decides not to move forward with treatment. Duplication of the following records (including but not limited to): x-rays, models, impressions, pour ups, wax ups, photos, lab work, etc. will carry a fee even if the patient decides to cancel treatment. If the insurance company remits a check to the patient, the patient must pay the SDA within five business days of receiving the check.

-SPECIAL ORDER: Special ordered parts and medical devices may have to be ordered and this will be determined on a patient by patient basis. Patient will be made aware of fee for special orders in advance, and assume full responsibility for cost of parts. If treatment is cancelled after order, patient will be subject to a 25% restocking fee for parts that are returnable. Please notice that some parts are not returnable items once they are opened by doctor or lab technician, or are used in mouth, at which point patient will still be responsible for full fee of parts/medical devices.

-RETURNED CHECK CHARGES: $25 plus any bank charges we may incur. Patient will have 3 days to bring cash to the office, or make full payment due by credit card, to replace returned check and bank charges. After 3 days, your account will be charged additional collection fees (40% of your current balance).

-BROKEN APPOINTMENTS/NO SHOW: A $50 per scheduled hour will be charged if cancelled or rescheduled within 24 hours of appointment time. All no shows for scheduled appointments will be charged $35 per scheduled hour. Payment of this fee will be collected before any further treatment is rendered.

-LAB CASES: Procedures and cases that require services from lab for crowns, bridges, dentures, partials, night guards, retainers, etc, 50% will be due when impressions are taken and the remaining balance is to be paid off before completion of treatment.

-SAME DAY SERVICES: All same day services, including but not limited to: Dentures, Repairs, Partials, must be paid for at time of service by credit card, cash or financing with one of our issuing banks. **NO** checks will be accepted.

-INSURANCE: Insurance claims will be filed as a courtesy to you. Your insurance is a contract between your Employer or Insurer, and you. Our total fees for completed treatment are due within 60 days of date of treatment, regardless if insurance has paid.We make every effort to verify and help get claims paid and are not responsible for denied claims. Insurance companies are changing the fine print of their policies, All insurance quotes given are *estimates* of your benefits. While we would like to advise you of your exact financial obligation before date(s) of service, the scale of different insurance plan designs make it extremely difficult. Your copayment or patient portion may vary based on actual payments made by your insurance provider. Claims for your dental care

Initial:_____

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FINANCIAL AGREEMENT

are submitted on the day treatment is completed. In the event that your insurance carrier remits less than the estimated amount of the claim, for an reason inclusive of denied claims, the patient/responsible party, is financially responsible to pay the unpaid balance. Copays are due on date of service. Benefits quoted are subject to your available benefits on the date insurance claim is received. This may include, but not limited to, a deductible, downgrading on posterior composites and crowns, bundling, or excluded services by your insurance policy. Patient/responsible party is responsible for knowing what benefits they have. Patient/responsible party is also responsible for providing complete and accurate insurance information for any primary/secondary insurance coverages and understands that failure to do so may result in claim denial. Shine Dental Associates reserves the right to close any unpaid claim that is older than 60 days from the date of service, and agrees to pay any balance remaining on their account after insurance claims are processed. If insurance is terminated, cancelled, and expected insurance payment is not received by Shine Dental Associates, patient assumes responsibility for balance due and will be expected to remit payment to bring account up to date. Patient treatment may exceed allowable fees on insurance plans that our office participates with. For non-covered services, service upgrades, or alternative treatment, patient has been presented with and is agreeable to, and assumes responsibility of upgraded fees. Patients, please be aware that certain providers may not participate with certain in insurance plans.

-FAMILY ACCOUNTS: All patients 18 and older must fill out and sign a financial agreement. The Guarantor of family account must sign a financial agreement. Anyone older than 18 years will ultimately be personally responsible for themselves.

-DIVORCED PARENTS: Copays for any services for dependents are due on date of service. Treatment plans are provided prior to appointments with estimated co-pays. If needed, a prior arrangement with a parent needs to be taken care of before the child's appointment. Copays need to be paid in full at or before the child's appointment.

-Patient acknowledges that changes in treatment may become necessary during the course of care. Patient understands that they will be kept informed of any necessary changes in treatment and acknowledges that they will be financially responsible for any such changes.

-Patient understands that any invoice or receipt issued by Shine Dental Associates is a non-binding estimate only, and additional charges may apply depending on patient following continuing care instructions given by providers of Shine Dental Associates,

-This Financial Agreement will apply to all family members unless specified otherwise.

-Patient grants permission to Shine Dental Associates, or to Office's assignee, to telephone patient to discuss matters related to this form.

-Patient has read the above conditions of treatment and payment, and agree to their content

-Orthodontic Patients: Retainers will not be given to the patient until orthodontic treatment is paid for in full.

Signature of Guarantor/ Responsible Party	Print	Date