PATIENT NAME **(please print!)**_________________________________DOB:__________________SS#___________________

ADDRESS:____ COLLEGE STUDENT? Y N

HOME PH:______________CELL:_____________WORK PH:___________EMAIL ADDRESS:_________________________

GENDER:______________MARITAL STATUS: __________EMPLOYER ____

SPOUSE NAME:_____________________________DOB: _________________________SS#________________________

IF PATIENT IS A CHILD – Parent or Guardian Name and address:____

*Please sign below as account holder for child

Are you the legal guardian of the patient?__Y__N If not do you have the legal authority to sign for consent?___Y___N

ARE YOU A MEDICARE ELIGIBLE PATIENT? Y N

NAME AND ADDRESS OF PRIMARY DENTAL
INSURANCE:____Employer:____________________________

Policy Holder:________________DOB of Policy Holder:________Policy #____________________Group #____________

NAME AND ADDRESS OF SECONDARY DENTAL
INSURANCE:____Employer:____________________________

Policy Holder:________________DOB of Policy Holder:________Policy #____________________Group #____________

ADDITIONAL INFORMATION: Who may we thank for referring you to our office?________________________________

Is another member of your family a patient at our office?____

IN CASE OF EMERGENCY: Name of nearest relative not living with you____________________Phone:_______________

HIPAA PRIVACY ACKNOWLEDGEMENT:
Lake Superior Dental Associates will use and disclose protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your PHI. You have the right to review our Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices. You have the right to request us to restrict how we use and disclose your PHI for the purposed of treatment, payment, and health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. A copy of Lake Superior Dental Associates Privacy Practices is available upon request.
PATIENT or Guardian **Signature**:____

Financial Agreement: I hereby authorize LSDA to furnish information to insurance carriers concerning my treatment and I hereby irrevocably assign to the doctor all payment for dental services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. See back of page for our financial policies.

AUTHORIZATION FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or dental treatment as deemed necessary or advisable by my dentist or dental provider at LSDA. SIGNATURE OF PATIENT or PARENT OR GUARDIAN OF PATIENT:____DATE:___________________________________

*See above –account holder and authorized signer SEE BACK SIDE……

PRESCRIPTIONS INVOLVING NARCOTICS: The Minnesota Prescription Monitoring Program requires Dentists who prescribe Schedule V or Tramadol and Butalbital, to obtain patient consent to access their database which monitors potential patient overuse of these controlled substances. Please sign for consent for LSDA to access this database. If you refuse consent, your Dentist at LSDA may choose not to prescribe the narcotic.
PATIENT or Guardian **Signature**:____DATE:_____________________

Lake Superior Dental Financial Policies & Procedures

STATEMENT INFORMATION We will provide you with a statement each month which shows your outstanding balance at the date of billing, all payments and credits applied against the account since the last billing, the Annual Percentage Interest Rate (APR), total finance charges and an itemized record of all charges incurred during that billing period.

FINANCE CHARGES will be .67% per month on any unpaid balance after deducting current payments, credits, and allowances from prior month's statement. The Finance Charge Begins to Accrue after the 2nd statement date (approximately 60 days) at a Rate of .67% per month or APR of 8%.

MEDICAL ASSISTANCE PATIENTS please inform our business office of any changes in your insurance coverage. You are responsible for payment on all non-covered services at the time of treatment.

MEDICARE ELIGIBLE PATIENTS we do not participate in the Medicare system. Very little dental care is covered by Medicare. A list of services is available upon request. Non-participation means that the patient pays Lake Superior Dental directly for any and all services performed.

Grand Portage Health Services Recipients: EFFECTIVE 4-1-18 each member has a $1000 maximum per year. Each service must be pre-authorized. We may not be able to accommodate your appointment in the time frame requested as Grand Portage Health Services must first approve your care and verify if you have benefits available. If you have used your allotment for the year, we will ask you to pay your portion the day services are rendered and/or we can also assist you in applying for Care Credit.

IMPORTANT – YOU ARE RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT REGARDLESS OF INSURANCE COVERAGE. Outstanding balances due to deductible or non-covered service are subject to the following credit policy. If your account becomes delinquent and enters into a collection status, you will be responsible for all collections/court costs incurred. (Regulation 2) Your account will also change status to a credit denied account and we will expect payment at the time of service.

CREDIT POLICY

OPTIONS

1. CASH/CHECK WITH 5% DISCOUNT – A 5% discount will be given the day of service for payment made IN FULL FOR TREATMENT with cash or a check. No Discount can be extended to treatment that will be submitted to insurance or to Grand Portage Health Services.

2. CREDIT CARDS – We will accept all valid major credit cards. No discount can be given with a credit card payment.

3. PAYMENT IN FULL UPON INSURANCE REIMBURSEMENT
   - If you have insurance coverage, you will receive a statement for any outstanding balance due after the insurance company has responded.
   - If the insurance payment goes directly to the insured, you will receive a statement for the full amount of treatment.
   - The due date for the balance will be on the statement. Finance charges will accrue after 60 days.

4. DOWN PAYMENT WITH BALANCE ON APPROVED SHORT-TERM CREDIT (FOR LARGE TREATMENT PLANS) *DOWN PAYMENT*
   - Down payment in the amount of 1/3 of the **total fee** will be required at the start of a large treatment.
   - The remaining balance for large treatment can be paid in up to 3 monthly payments if arrangements are made prior to treatment. Finance charges will begin to accrue at 60 days.

5. CARE CREDIT Credit Card – For patients that would like to make smaller payments for treatment, we accept the health care financing program Care Credit in our office. For more information about this program please ask in our business office, visit www.carecredit.com, or call 1-800-365-8295.

Check Payments

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. There will be a $30 returned check charge on all NSF checks.

Cancellation and No-Show Policy

We understand that there are times when something unforeseen comes up and you must cancel or reschedule your appointment. In that event we ask that you notify us as soon as possible so that your appointment time may be filled by another patient needing care. We do enforce the following policy for Cancellation/No-Show appointments: Cancellations – If an appointment is not cancelled AT LEAST 24 HOURS IN ADVANCE of the scheduled time, you will be assessed at $25 fee. This will not be covered by insurance. No Shows – If you DO NOT ATTEND A SCHEDULED APPOINTMENT, and do not call to cancel 24 hours in advance, you will be assessed a $50 fee. This will not be covered by insurance. If you have 2 no-shows in a row, all future appointments will be removed from the schedule.

I acknowledge that I have read LSDA Financial Policies and Procedures and that I am responsible for all charges whether or not covered by insurance.

Patient Signature:____DATE:____________________