MICHAEL MANASAR DENTISTRY

PATIENT REGISTRATION

Patient Name: _____ DOB: _____ Age: _____ Gender: M F

Social Security: _____ Drivers License: _____

Home Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____ Marital Status: S M D W Other: _____

Place of Employment: _____ Occupation: _____

Address of Employment: _____ City: _____ State: _____ Zip: _____

Spouse Name: _____ DOB: _____ Age: _____ Gender: M F

Spouse Social Security: _____ Drivers License: _____

Spouse Phone: _____ Spouse Email:_____

How did you hear about this office? _____

EMERGENCY CONTACT INFORMATION

Name, Address, Telephone number of a person or relative not living with you.

Name: _____ Address: _____

Phone: _____ Alt Phone: _____ City: _____ State: _____ Zip: _____

Physician: _____ Address: _____

Physician Phone: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION (Primary)

Insured Name: _____

DOB: _____ SSN: _____

Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____

Group #: _____ Policy #: _____

Insured relationship to patient: _____

DENTAL INSURANCE INFORMATION (Secondary)

Insured Name: _____

DOB: _____ SSN: _____

Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____

Group #: _____ Policy #: _____

Insured relationship to patient: _____

I verify the accuracy of the above information and authorize release of information necessary to process any insurance claim.

Patient Signature (or Parent of Child): _____ Date: _____

MICHAEL MANASAR DENTISTRY

DENTAL HISTORY

Do you have, or have you ever had any of the following?

Please check the following:	YES	NO
Back pain?	☐	☐
Bad breath?	☐	☐
Bleeding, swollen, or irritated gums?	☐	☐
Broken teeth or fillings?	☐	☐
Do you have sleep apnea?	☐	☐
Do you snore?	☐	☐
Do you grind or clench you teeth?	☐	☐
Headaches, ear aches, neck aches?	☐	☐
Jaw joint pain?	☐	☐
Loose, tipped or shifting teeth?	☐	☐
Mouth ulcers or cold sores?	☐	☐
Sensitivity (hot, cold, sweet)	☐	☐
Where? UR UL LR LL		
TMJ / TMD problems or pain?	☐	☐

With regards to your current smile, please note the following:

	YES	NO
If you could whiten your teeth for an affordable price, would you do it?	☐	☐

If you could change your smile, you would:

Make your teeth whiter	☐	☐
Make your teeth straighter	☐	☐
Close spaces between your teeth	☐	☐
Repair your chipped teeth	☐	☐
Replace your missing teeth	☐	☐
Replace old crowns that don't match	☐	☐
Have a smile make over	☐	☐

Do you have, or have you ever had any of the following?

Please check the following:	YES	NO
Dentures	☐	☐
Partial dentures	☐	☐
Dental implants	☐	☐
Braces	☐	☐
Gum / Periodontal treatments	☐	☐

On a scale of 1 – 10, with 10 being the highest rating, how would you rate the following?

The importance of your dental health?

1 2 3 4 5 6 7 8 9 10

Your current dental health?

1 2 3 4 5 6 7 8 9 10

Name of Previous Dentist: _____

City: _____ State: _____

Phone Number: _____

Why did you leave your previous dentist? _____

_____

Please share the following:

Date of your last dental cleaning: ____/ ____

Date of your last oral cancer screening: ____/ ____

Date of your last complete x-rays: ____/ ____

What is the most important that that we can do for you during your visit with us today?

_____

_____

_____

Is there any other dental information we should know about? _____

_____

_____

_____

MICHAEL MANASAR DENTISTRY

MEDICAL HISTORY

Do you have, or have you ever had any of the following?

	YES	NO		YES	NO
AIDS / HIV positive	☐	☐	Heart attack	☐	☐
Alzheimer's disease	☐	☐	Heart murmur	☐	☐
Anaphylaxis	☐	☐	Heart Pacemaker	☐	☐
Anemia	☐	☐	Hepatitis A / B / C	☐	☐
Angina	☐	☐	High or low blood pressure	☐	☐
Arthritis / Gout	☐	☐	Hypoglycemia	☐	☐
Artificial heart valve	☐	☐	Irregular heartbeat	☐	☐
Asthma	☐	☐	Kidney problems	☐	☐
Blood disease	☐	☐	Leukemia	☐	☐
Bleeding problems	☐	☐	Liver disease	☐	☐
Bruises easily	☐	☐	Mitral valve prolapse	☐	☐
Cancer	☐	☐	Osteoporosis (Fosamax/Actonel/Boniva)	☐	☐
Chemotherapy	☐	☐	Parathyroid disease	☐	☐
Cold sores / Fever blisters	☐	☐	Psychiatric care	☐	☐
Congenital heart disorder	☐	☐	Radiation treatments	☐	☐
Convulsions	☐	☐	Recent weight loss	☐	☐
Cortisone medication	☐	☐	Renal dialysis	☐	☐
Diabetes	☐	☐	Shingles	☐	☐
Drug addiction	☐	☐	Sickle cell disease	☐	☐
Emphysema	☐	☐	Sinus trouble	☐	☐
Epilepsy / Seizures	☐	☐	Swelling of the limbs	☐	☐
Excessive bleeding	☐	☐	Thyroid disease	☐	☐
Excessive thirst	☐	☐	Tonsillitis	☐	☐
Fainting Spells	☐	☐	Tuberculosis	☐	☐
Frequent headaches	☐	☐	Tumors or growths	☐	☐
Glaucoma	☐	☐	Ulcers	☐	☐

Other conditions not listed: _____

Are you currently under the care of a physician? YES NO If yes, please explain: _____

_____

FOR WOMEN ONLY	YES	NO
Are you using birth control pills?	☐	☐
Are you currently breast-feeding?	☐	☐
Are you currently pregnant?	☐	☐

If yes, Please indicate:

Unsure 1-3 months 3-6 months 6-9 months

Do you have allergies to *any* of the following?

	YES	NO		YES	NO
Amoxicillin	☐	☐	Latex	☐	☐
Aspirin	☐	☐	Codeine	☐	☐
Erythromycin	☐	☐	Penicillin	☐	☐
Local anesthetic	☐	☐	Nitrous	☐	☐
Other: _____				☐	☐

What medications or supplements are you currently taking? **Dose** **Reason**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

MICHAEL MANASAR DENTISTRY
83 East Main Street
WAPPINGERS FALLS, NY 12590
Phone: 845-297-6432
Email: MManasarDentistry@gmail.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:
We, MICHAEL MANASAR DENTISTRY, understand that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all the records of your care generated by MICHAEL MANASAR DENTISTRY, whether made by MICHAEL MANASAR DENTISTRY personnel or your personal doctor or other health care provider. This Notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information.
The law requires us to:

- make sure that protected health information that identifies you is kept private
- notify you about how we protect protected health information about you
- explain how, when and why we use and disclose protected health information
- follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- posting the revised Notice in our office
- making copies of the revised Notice available upon request
- posting the revised Notice on our website.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other MICHAEL MANASAR DENTISTRY personnel who are involved in taking care of you. MICHAEL MANASAR DENTISTRY staff may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected health information about you to people outside MICHAEL MANASAR DENTISTRY who may be involved in your medical care. We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at MICHAEL MANASAR DENTISTRY. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services.

Payment: We may use and disclose protected health information about you so that the treatment and services you receive at MICHAEL MANASAR DENTISTRY may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at MICHAEL MANASAR DENTISTRY so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Healthcare Operations: We may use and disclose protected health information about you for MICHAEL MANASAR DENTISTRY health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care. We may also combine protected health information about many MICHAEL MANASAR DENTISTRY patients to decide what additional services MICHAEL MANASAR DENTISTRY should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other MICHAEL MANASAR DENTISTRY personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study healthcare and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort. Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.

As Required By Law: We will disclose protected health information about you when required to do so by federal, state or local law.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Health Risks: We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.

Business Associates: We may disclose information to business associates who perform services on our behalf (such as billing companies); however, we require them to appropriately safeguard your information.

Public Health: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, which may be necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement: We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

Organ and Tissue Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Special Government Functions: If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans' activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Correctional Institutions and Other Law Enforcement Custodial Situations: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

Worker's Compensation: We may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Food and Drug Administration: We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES
Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

- We may share with a family member, relative, friend, or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. We may also share information to notify these individuals of your location, general condition or death.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact information listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU
You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to MICHAEL MANASAR DENTISTRY. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Right to Amend: If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted to MICHAEL MANASAR DENTISTRY. In addition, you must provide a reason that supports your request. We will act on the/ your request for an amendment no later than 60 days after receiving the request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the protected health information kept by MICHAEL MANASAR DENTISTRY.
- Is not part of the information which you would be permitted to inspect and copy, or
- We believe is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you. To request this list or accounting of disclosures, you must submit

your request in writing to MICHAEL MANASAR DENTISTRY. You may ask for disclosures made up to six years before your request (not including disclosures made before December 7, 2016). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.

We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on previous pages. To request restrictions, you must make your request in writing to MICHAEL MANASAR DENTISTRY.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to MICHAEL MANASAR DENTISTRY. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time by contacting MICHAEL MANASAR DENTISTRY.

OTHER USES AND DISCLOSURES
We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES
If you believe your privacy rights have been violated, you may file a complaint with MICHAEL MANASAR DENTISTRY or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence of the complaint or violation. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

This notice was published and becomes effective on/or before **January 01, 2021.**

Michael Manasar Dentistry
83 East Main Street
Wappingers Falls, NY 12590

Acknowledgement of Receipt of Notice of Privacy Practices
* You May Refuse to Sign This Acknowledgment *

I have received a copy of this office's Notice of Privacy Practices

Please Print Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other: _____

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

(Initial below)

I _____ DO AGREE

I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

Michael Manasar Dentistry will communicate via end to end encrypted email for all patient record requests.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging

____ Email

I would like to receive:

____ Appointment Reminders/Recall Visits

____ Information regarding insurance/billing

____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling: Michael Manasar Dentistry:

Phone: 845-297-6432. Email: MManasarDentistry@gmail.com

Patient Signature: _____ Date:_____

MICHAEL MANASAR DENTISTRY

Pre-Appointment COVID-19 Screening Form

Patient Name: _____

	PRE-APPOINTMENT		IN-OFFICE	
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes	No	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No	Yes	No
Do you/they have a cough?	Yes	No	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes	No	Yes	No
Have you/they experienced recent loss of taste or smell?	Yes	No	Yes	No
Are you/they in contact with any confirmed COVID-19 patients? *Patients who are well but ho have a sick family member at home with COVID-19 should consider postponing elective treatment*	Yes	No	Yes	No
Is your/their age over 60?	Yes	No	Yes	No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes	No	Yes	No
Have you/they traveled in the last 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes	No	Yes	No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

MICHAEL MANASAR DENTISTRY

General Dental Treatment Consent Form

Dentist Name: _____ **Patient Name:** _____

Please read and initial the items checked below and read and sign at the bottom of the form

1. Dental X-Rays Initial _____

2. Drugs & Medications Initial _____

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylacyc shock (sever allergic reaction).

3. Changes in Treatment Plan Initial _____

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. Removal of Teeth Initial _____

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove specified teeth and any other necessary for reasons discussed at consultation. I understanding removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during the treatment, the cost of which is my responsibility.

5. Crowns & Bridges Initial _____

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation.

6. Dentures (Complete/Partial) Initial _____

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

7. Endodontic Treatment Initial _____

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

8. Periodontal Loss Initial _____

Periodontal disease is a chronic inflammatory condition that left untreated, can cause inflammatory bony resorptioin resulting in loss of permanent teeth. I understand that my condition will be assessed and treatment that may or may not include some of all of the following: deep clean, extractions, referral to a specialist. I understand that the success of periodontal treatment depends on my adherence to following my dentist's instructions, including hygiene appointment frequency.

9. Fillings Initial _____

I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

10. Dentures Initial _____

I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

I understand that dentistry is not an exact science and therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian (if patient is a minor):_____ Date: _____

MICHAEL MANASAR DENTISTRY

Financial Guidelines

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available upon request and approval.

Please Note: Returned checks will be subject to an additional fee of $40. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

For those patients who are covered by insurance, we will be happy to bill on your behalf. Please note fees will be dependent on the provider, not the insurance company. Verification of benefits is not a guarantee of coverage. Medical necessity is up to the determination of your insurance provider. You, the patient, may be responsible for services, as Michael Manasar Dentistry is not contracted with any insurance companies.

We will collect payment at the end of your visit, and submit an insurance claim on your behalf. We are unable to accept assignment of benefit on your behalf, therefore the reimbursement check will be mailed directly to you. In the instance that assignment of benefit accidently occurs, the refund check will be sent directly to you. Payment in full is due at time of procedure. Any outstanding balance that is your responsibility will be expected to be paid in full within 30 days of notification.

I understand that I will be expected to pay for all applicable fees the day of service. I understand that I am responsible for the full cost of my visit. I understand that Michael Manasar Dentistry and the team cannot guarantee any reimbursement from the insurance company. I will assume responsibility of notifying this office of any changes in insurance coverage. I authorize Michael Manasar Dentistry to submit insurance claims on my behalf, and that they will accept assignment of benefit – if possible. Otherwise, they cannot accept payment from my insurance company, and payment will go directly to me.

I authorize the office of Michael Manasar Dentistry to release to any company providing me with dental insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by Michael Manasar Dentistry, for the purpose of billing (if applicable).

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Michael Manasar Dentistry to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment.

_____ (initial) I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

_____ (initial) I agree that this non credit card challenge agreement is irrevocable.

I agree to this financial policy. I have read and received a copy of this document. I authorize my insurance company (if applicable) to pay my dental benefits directly to my dental office.

Patient Name: _____

Patient Signature:_____ Date:_____