

# Frank P. Benson, D.M.D.

Periodontics • Implant Dentistry • T.M.J./Facial Pain

International Congress of Oral Implantologists • American Dental Association • Academy of Osseointegration  
American Academy of Periodontology • American Academy of Implant Dentistry • Georgia Dental Association

Patient's Name \_\_\_\_\_ Familiar Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Partnered  Widowed

Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_ Company \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone + Extension \_\_\_\_\_ Pager/Mobile \_\_\_\_\_

General Dentist \_\_\_\_\_ Referring Doctor \_\_\_\_\_

**If different, give the person's name responsible  
for account or *person's name with insurance*:**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ Company \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced  Widowed

Contact for Emergency:

Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone + Extension \_\_\_\_\_ Pager/Mobile \_\_\_\_\_

## FINANCIAL INFORMATION AND POLICIES

**WELCOME TO OUR PRACTICE!!** As a patient in our office, you are entitled to a clear understanding of your financial options prior to receiving treatment. I am happy to provide you with the support of a front office staff highly trained in financial options and insurance benefits. They are happy to answer all of your questions. Below please find the basic guidelines concerning financial arrangements and acceptance of insurance benefits.

### General and Surgical Care

You are the most important factor regarding your health. Treatment is determined by your individual needs, not your insurance benefits. Fees are based on the services we provide and not on your insurance benefit payments. After consulting with Dr. Benson, you will ultimately decide the best course of treatment. Payment in full is due at the time services are rendered unless alternative arrangements have been made in advance. For your convenience, we accept Visa & MasterCard.

### Insurance Benefits

Many of our patients have insurance benefits. Those benefits are determined by the plan purchased for you by your employer. Internal fee schedules, "usual & customary" limitations or refusals to cover certain procedures are all efforts by insurance carriers and employers to control the cost of the insurance coverage provided to employees. Most plans base the amount of your benefit on a schedule of fees arbitrarily developed by insurance companies. Thus, the quoted benefits are based on business decisions by the insurance company and not on actual fees charged by this practice or other practices in this area. Therefore, you may receive less reimbursement than your plan appears to promise. If you feel your coverage is insufficient you need to address that issue with your employer.

As a courtesy to you, we are happy to submit your claims and assist you in receiving reimbursement. To speed processing, please provide us with complete and accurate information prior to treatment. **The initial visit and any visit totaling \$150 or less requires payment in full at the time of that appointment.** After the first visit and once benefits have been verified, my staff will estimate your benefits for services over \$150.

You are responsible for your estimated portion for services over \$150 at the time service is rendered. We will accept the estimated benefit directly from your insurance carrier. *Keep in mind that estimates given by the carrier over the phone are informational only and not a guarantee of payment. If your carrier does not pay within 60 days after the date of service or does not pay the full estimated copayment, you are responsible for the balance.* Due to the delay and uncertainty of secondary policies we do not estimate your benefits available through them nor will we wait for payment from them. Regardless of insurance coverage, you are always ultimately responsible for your account balance.

In the case of injuries covered by Worker's Compensation or 3rd party insurance, it is strict office policy that no benefits are accepted as payment. The patient must pay for treatment as services are rendered. If Dr. Benson is asked to write a special report, there will be an additional charge for the time and effort involved in creating that documentation.

### Insurance Information

Dental Insurance Company: \_\_\_\_\_ PH #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employee: \_\_\_\_\_ DOB: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Group#: \_\_\_\_\_ Patient Relation to Insured: Self Spouse Child Other

Medical Insurance Company: \_\_\_\_\_ PH #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employee: \_\_\_\_\_ DOB: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Group#: \_\_\_\_\_ Patient Relation to Insured: Self Spouse Child Other

**Patient Acknowledgement:** By my signature below, I acknowledge that I have read and understand the policies of this office. In cases where it has been agreed that payment is to be accepted directly from the insurance company, I authorize payment directly to the provider. In the case of an overpayment, I have the option of leaving a credit on the account or receiving a refund for the difference.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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## PATIENT CONSENT FORM

**I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:**

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

**I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.**

**I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.**

**I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.**

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Print Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_