

**ADULT MEDICAL HISTORY FORM pg1**

**SELECT YOUR DENTIST:**

**Dr. Will Turner**

**Dr. Jason Butler**

**DATE:** \_\_\_\_\_

**Dr. Melissa Owen**

**PATIENT INFORMATION:**

Name \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE INITIAL)

Married  Single

Male  Female

What name would you like to be called in this office? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**FAMILY INFORMATION:**

**SELF**

**SPOUSE**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home# \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_  
Cell # \_\_\_\_\_ Pager \_\_\_\_\_  
Email: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Employer/Occupation: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home# \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_  
Cell # \_\_\_\_\_ Pager \_\_\_\_\_  
Email: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Employer/Occupation: \_\_\_\_\_

Please name two people to contact outside of immediate family in case of emergency: (not living with you)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**FINANCIAL INFORMATION:** (note: please review our Financial Policy form)

Please check the person financially responsible for the account

Patient  Father  Mother  Guardian  Spouse  Other (specify) \_\_\_\_\_

Does responsible party have an account with this office  Yes  No

Method of Payment:  Check  Cash  Mastercard/Visa

Where appropriate and necessary, credit bureau reports will be obtained.

**Dental Insurance 1**

**Dental Insurance 2**

Employee Name: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
\_\_\_\_\_  
Subscriber I.D. #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Employee Date of Birth: \_\_\_\_\_

Employee Name: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
\_\_\_\_\_  
Subscriber I.D. #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Employee Date of Birth: \_\_\_\_\_

**Authorization:**

I hereby authorize payment directly to the Drs. Turner & Butler, DMD, PA, as well as, the Associate dentist of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **State Driver's License #:** \_\_\_\_\_

Please complete the following page regarding Medical History

## ADULT MEDICAL HISTORY FORM pg2

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.**

Are you under a physician's care now?    \_\_\_ Yes \_\_\_ No    If yes, please explain \_\_\_\_\_  
 Have you ever been hospitalized or had a major operation?    \_\_\_ Yes \_\_\_ No    If yes, please explain \_\_\_\_\_  
 Have you ever had a serious head or neck injury?    \_\_\_ Yes \_\_\_ No    If yes, please explain \_\_\_\_\_  
 Are you taking any medications? (Rx, OTC, Supplements)    \_\_\_ Yes \_\_\_ No    If yes, please list all here \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?    \_\_\_ Yes \_\_\_ No    If yes, please explain \_\_\_\_\_  
 Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?    \_\_\_ Yes \_\_\_ No    If yes, please explain \_\_\_\_\_  
 Are you on a special diet?    \_\_\_ Yes \_\_\_ No    If yes, please explain \_\_\_\_\_  
 Do you use tobacco?    \_\_\_ Yes \_\_\_ No  
 Do you use controlled substances?    \_\_\_ Yes \_\_\_ No  
 Do you have sleep apnea?    \_\_\_ Yes \_\_\_ No  
 Do you use a C-PAP machine?    \_\_\_ Yes \_\_\_ No  
 Do you use Electronic cigarette?    \_\_\_ Yes \_\_\_ No

**Women are you**  
 \_\_\_ Pregnant or Trying to get pregnant?  
 \_\_\_ Nursing?  
 \_\_\_ Taking oral contraceptives

Are you allergic to any of the following?  
 \_\_\_ Aspirin \_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Acrylic \_\_\_ Metal \_\_\_ Latex \_\_\_ Sulfa Drugs \_\_\_ Local Anesthetics  
 \_\_\_ Other            If yes, please explain: \_\_\_\_\_

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

___ AIDS/HIV Positive	___ Chest Pains	___ Genital Herpes	___ Kidney Problems	___ Rheumatism
___ Alzheimer's Disease	___ Cold Sores/Fever Blisters	___ Glaucoma	___ Leukemia	___ Scarlet Fever
___ Anaphylaxis	___ Congenital Heart Disorder	___ Hay Fever	___ Liver Disease	___ Shingles
___ Anemia	___ Convulsions	___ Heart Attack/Failure	___ Low Blood Pressure	___ Sickle Cell Disease
___ Angina	___ Cortisone Medication	___ Heart Murmur	___ Lung Disease	___ Sinus Trouble
___ Arthritis/Gout	___ Diabetes	___ Heart Pace Maker	___ Mitral Valve Prolapse	___ Spina Bifida
___ Artificial Heart Valve	___ Drug/Alcohol Addiction	___ Heart Trouble/Disease	___ Organ Transplant	___ Stomach/Intestinal
___ Artificial Joint	___ Easily Winded	___ Hemophilia	___ Osteoporosis	___ Stroke
___ Asthmas	___ Emphysema	___ Hepatitis A	___ Pain in Joints	___ Swelling of Limbs
___ Blood Clot/DVT	___ Epilepsy or Seizures	___ Hepatitis B or C	___ Parathyroid Disease	___ Thyroid Disease
___ Blood Disease	___ Excessive Bleeding	___ Herpes	___ Psychiatric Care	___ Tonsillitis
___ Blood Transfusion	___ Excessive Thirst	___ High Blood Pressure	___ Radiation Treatment	___ Tuberculosis
___ Breathing Problems	___ Fainting Spells/Dizziness	___ High Cholesterol	___ Recent Weight Loss	___ Tumors or Growths
___ Bruise Easily	___ Frequent Cough	___ Hives or Rash	___ Renal Dialysis	___ Ulcers
___ Cancer	___ Frequent Diarrhea	___ Hypoglycemia	___ Rheumatic Fever	___ Venereal Disease
___ Chemotherapy	___ Frequent Headaches	___ Irregular Heartbeat		

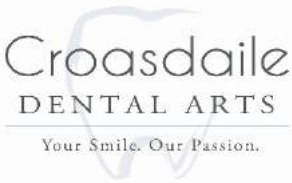
Have you ever had any serious illness not listed above?    \_\_\_ Yes \_\_\_ No    If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**I understand that Croasdaile Dental Arts (Drs. Turner & Butler, DMD, PA) and their associate dentist requires that a new Medical History Form be completed once a year.**

**Signature of Patient, Parent or Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Adult New Patient  
Dental History Questionnaire**

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**What would you like to accomplish today?** \_\_\_\_\_

What prompted you to seek dental care at this time? \_\_\_\_\_

Have you been asked to take an antibiotic before dental treatment?  Yes  No

**Please check if you have ever had problems with any of the following:**

Sensitivity to cold       Jaw/ear pain       Bleeding Gums       Food sticks  
between teeth

Sensitivity to hot       Grinding/clenching teeth       Periodontal treatment       Mouth sores/growths

Sensitivity when biting       Clicking or popping jaw       Loose teeth/broken fillings       Bad Breath/Taste

Sensitivity to sweets       Worn/chipped teeth       Dark teeth       Hard to floss

**Home Care Evaluation**

How often do you brush? \_\_\_\_\_ Toothbrush:  Electric  Regular  Soft  Medium  Hard

How often do you floss? \_\_\_\_\_ Any other homecare devices that you use? \_\_\_\_\_

Is it difficult for you to brush or floss any areas of your mouth?  Yes  No

If yes, please describe: \_\_\_\_\_

Do your gums bleed when brushing or flossing?  Yes  No

Do you have dry mouth?  Yes  No

Do you want to learn to control dental disease & keep your teeth?  Yes  No

Have you ever been instructed in the prevention of decay?  Yes  No

Have you been instructed in caring for the health of your gums?  Yes  No

Do you feel like keeping your teeth healthy has been a losing battle?  Yes  No

If yes, why? \_\_\_\_\_

Do you have any concerns about getting your mouth in excellent health?  Yes  No

If yes, what concerns you? \_\_\_\_\_

Do you snack between meals on sweets, gum or soda pop?  Yes  No

Do you chew on both sides of your mouth?  Yes  No

Unsure

**Smile Evaluation**

What do you like about your smile? \_\_\_\_\_

What don't you like about your smile? \_\_\_\_\_

Do you sometimes hesitate to smile?  Yes  No

Are your teeth white enough?  Yes  No

Are there old fillings or dental work that look bad to you?  Yes  No

Do you like the shape of your teeth?  Yes  No

Are your teeth straight enough?  Yes  No

Do you have spaces between your teeth that you don't like?  Yes  No

Has cost prevented you from enhancing your smile in the past?  Yes  No

**Other History**

Are you anxious about receiving dental treatment?  Yes  No

If yes, what do you dislike? \_\_\_\_\_

Has fear of discomfort kept you from regular dental visits in the past?  Yes  No

What else would you like us to know about your past dental experiences?  
\_\_\_\_\_

Have you ever had a reaction to a dental product or procedure?  Yes  No

If yes, please describe: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_, State \_\_\_\_\_

Date of Last visit: \_\_\_\_\_ Date of Last X-rays: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_



### **Missed Appointment Policy**

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments. If you are unable to do so, please notify us at least 24 hours in advance. When you provide us with 24 hours' notice we are able to accommodate other patients in need of treatment.

**Please read our policy as indicated below:**

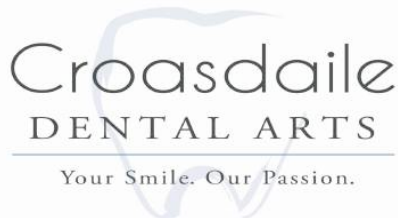
**Cancellations are requested with 24 hours notice, otherwise it is concerned a missed appointment.**

- **First missed appointment** – We realize patients get sick, people sometimes forget, or another emergency arises. As soon as you are aware that you can't make the appointment, call us – even late at night you are able to leave a message on our answering machine. Typically, we don't charge for the first missed appointment; however, we do reserve the right to do so.
- **Second missed appointment** – A missed appointment fee of \$50.00 will be charged to your account. This will be charged per family member if multiple appointments scheduled and broken. Please note: Insurance will **not** pay for this charge. We require that the missed appointment fee be paid in full before scheduling another appointment.
- **Third missed appointment** - You will be charged another \$50.00 missed appointment fee. In addition, we also reserve the right to dismiss you from our practice.

Note: Parents bringing in two or more family members at the same time will be restricted from scheduling a double or triple appointment after missing two such appointments for multiple family members.

Thank you for your courtesy.

(Note: Prior to implementation the policy and notification process have been approved and met the requirements of the North Carolina Dental Society and was also reviewed by our attorney.)  
Updated 07/27/17



**Drs. Turner & Butler, DMD, PA  
Dba Croasdaile Dental Arts  
2900 Croasaile Drive, Ste  
Durham, NC 27705**

## **Notice of Privacy Practices**

**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.**

**If you have any questions about this Notice please contact the Privacy Officer.  
Kim Dodson or Christi Bintliff**

**Effective Date: April 14, 2003**

**Revised: April 11, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: [www.croasdailedentalarts.com](http://www.croasdailedentalarts.com)

### **Uses and Disclosures of Protected Health Information**

**We may use or disclose (share) your PHI to provide health care treatment for you.**

Your PHI 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 providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

**We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.**

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

**We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.**

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

**We may use and disclosure your PHI in other situations without your permission:**

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Other uses and disclosures of your health information.**

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

**We may use or disclose your PHI in the following situations UNLESS you object.**

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

**The following uses and disclosures of PHI require your written authorization:**

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

### **Your Privacy Rights**

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

#### **You have the right to see and obtain a copy of your protected health information.**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

#### **You have the right to request a restriction of your protected health information.**

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

**There is one exception:** we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

#### **You have the right to request for us to communicate in different ways or in different locations.**

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

#### **You may have the right to request an amendment of your health information.**



You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

**You have the right to a list of people or organizations who have received your health information from us.**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

**Additional Privacy Rights**

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation, we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

**Complaints**

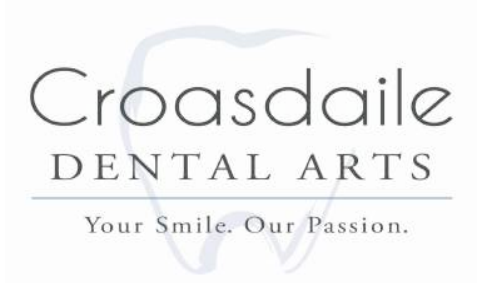
If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Kim Dodson, HIPAA Compliance Officer 919-383-7402

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint, we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003



**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **NOTICE OF PRIVACY PRACTICES** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **NOTICE OF PRIVACY PRACTICES**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

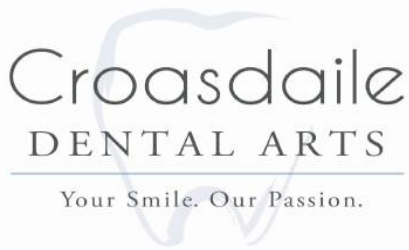
Patient Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

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**Office Use Only**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_



**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Croasdaile Dental Arts is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instructions.**

<b>Entity to Receive Information.</b> Check each person/entity that you Approve to receive information	<b>Description of information to be released.</b> Check each that can be given to person/ entity on the left in the same section.
<input type="checkbox"/> VOICE MAIL/ANSWERING MACHINE	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Appointments, follow-up calls or insurance
<input type="checkbox"/> EMAIL Email address _____  <input type="checkbox"/> TEXT APPTS to # _____	<input type="checkbox"/> Financial <input type="checkbox"/> Correspondences: Recall cards, newsletters, announcements, etc. <input type="checkbox"/> Appointments, follow-up calls or insurance.
<input type="checkbox"/> SPOUSE (provide full name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Appointments, follow-up calls or insurance.
<input type="checkbox"/> PARENT (provide names) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Appointments, follow-up calls or insurance.
<input type="checkbox"/> OTHER (provide names) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Appointments, follow-up calls or, insurance.

**Patient Information**

I understand that I have the right to revoke this information at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse or sign this authorization and that my treatment will be conditioned on signing. **This authorization shall be in effect until revoked by patient.**

Signature of Patient or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Description of Personal Representative's Authority: \_\_\_\_\_

Revised 5/27/17



Drs. Turner & Butler, DMD, PA  
DbA: CROASDAILE DENTAL ARTS  
2900 Croadaile Dr, Ste 5  
Durham, NC 27705  
919-383-7402 office

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## FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent your benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance affordable.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment.

### Payments

We accept the following forms of payment: CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS and DISCOVER. For your convenience, you may pay account balances electronically through [www.patientpaycenter.com](http://www.patientpaycenter.com) and use the office statement code: YDV1H9. In addition, we offer CARE CREDIT and SPRINGSTONE, a patient payment program offering a full range of No Interest and Extended Payment Plans for treatment fees.

Payment is expected at the time of your services. If you have dental insurance, we will provide an estimate of your co-payment and collect your portion at the time of your appointment. If an overpayment is made, you will receive a refund once all claims are processed.

You will receive a statement for balance due within 30 days, as well as, balance due after insurance letter. If you do not please contact the billing office 919-383-7402.

A finance charge of 1.5% will be assessed monthly to account balance after 60 days.

Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. Once accounts are turned over to the collection agency you will be dismissed from the practice. The responsible party of the account will receive notification via certified mail. You have 30 days from receipt of notification to find a new dentist.

Return check fee is \$25. We have the right to seek appropriate relief from the court of proper jurisdiction for full payment plus all costs, treble damages, and witness fees in accordance to North Carolina law, if payment has not been received within 30 days of notification

A credit report is required for all financial arrangements made within the practice

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment to your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our staff at any time to discuss any concerns you may have.

### Dental Insurance

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to *assist* in the cost of dental care. To avoid surprises on your bill, it is important to understand what your insurance will cover, and what you will need to cover in some other way. Dental benefits should not be confused with the dental services you need. We do not participate in any dental insurance networks.

As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will confirm your coverage and plan and we will estimate the insurance portion and your co-payment. This may or may not be what the insurance company will actually pay. Your plan may base its dollar allowance on a usual and customary fee schedule which may not coincide with current fees in our area. We'll do our best to help you receive maximum benefits. Patients are responsible for all balances incurred for services received.

If you are unable to present a valid member identification card from your carrier at your visit, we will expect payment in full until you are able to verify your insurance coverage.

We will wait 60 days for insurance claims to be paid. After 60 days if payment has not been made, you will be asked to pay the balance and seek reimbursement from your insurance company.

**Divorce Parents:**

In the case of a divorce, regardless of decree, the parent authorizing treatment for child(ren) will be the parent responsible for those subsequent charges. We are unable to bill separate parties; therefore it is the parent's responsibility to work out these details of payments.

**Patient under the age of 26**

Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent accompanying a minor child is responsible for payment. If your child is over 18 and you will not be accompanying him/her to the appointment, please send payment along with your child or call with a card number to run while they are here.

**Missed Appointment**

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as for other patients. If you find that you must change your appointment, we require a minimum of 48 hour notice, so that we can make every effort to accommodate other patients. If proper notice is not received, we reserve the right to charge a missed appointment fee of \$50 for every hour of allotted time that was cancelled. . The 3<sup>rd</sup> missed appointment could result in being dismissed from the practice.

**Waiver of Confidentiality:** You understand if we submit your account to an attorney or collection agency, if we have to litigate in court, or your past due status is reported to a credit report agency, the fact that you received treatment at our office may become a matter of public record.

**Charges for Phone Calls:** If a dentist is called, either after hours or during weekends or holidays, for prescriptions or refills a charge of \$25.00 may be assessed. Charge is waived if the patient is seen in the office.

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**Acknowledgement**

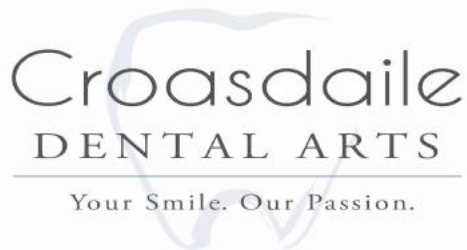
I have read this Patient Financial Policy as outlined, and understand that I am ultimately responsible for the charges incurred by me or by child(ren) as their legal parent or guardian.

This is an agreement between Drs. Turner & Butler, DMD, PA as creditor, the Patient/Guardian, or Parent as debtor, named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Printed Name \_\_\_\_\_



**Drs. Turner & Butler, DMD, PA**  
**DBA: Croasdaile Dental Arts**  
**2900 Croasdaile Drive, Suite 5**  
**Durham, NC 27705**  
**919-383-7402 office**

**Medicare Private Contract**

This contractual agreement is between Drs. Turner & Butler, DMD, PA and \_\_\_\_\_ (“Patient”). As dentist who have **OPTED-OUT** of Medicare on September 1, 2004 (effective date) Drs. Turner, Butler and their associate, Dr. Cole have informed Patient or his/her legal representative that treatment they provide to any Medicare beneficiary is not subject to Medicare limits.

As required by law, this agreement clearly states that Drs. Turner & Butler, DMD, PA are providers in good standing with the Medicare program under Section 1128, 1156 or 1892 of the Social Security Act.

By signing this contract the patient or his/her legal representative agrees with the following:

- A. Patient or his/her legal representative accepts full responsibility for payment of the Dentist’s charge for all services furnished by Dentist.
- B. Patient or his/her legal representative understands that Medicare limits do not apply to what the Dentist may charge for services.
- C. Patient or his/her legal representative understands that they **cannot submit a claim** to Medicare, Medicare Advantage or Medicare Replacement policies.
- D. Patient or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare covered items and services from physicians and practitioners who have not opted-out of Medicare.
- E. Patient or his/her legal representative understands that medigap or supplemental plans may elect not to make payments for services not filed or paid for by Medicare.

This contract shall remain in force from date signed by the patient or his/her legal representative until the Dentist informs patient that the OPT-OUT period has been cancelled.

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

Patient/Legal Representative: \_\_\_\_\_

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

DATE: \_\_\_\_\_



## **Dental Insurance Facts**

### **Fact 1 — NO INSURANCE PAYS 100% OF ALL PROCEDURES**

If your insurance stated they will pay 100% of a procedure. It is based on the insurance company's fee list (called an UCR list) and not the individual dentist's fee list.

Example: A procedure cost is \$180.00, your insurance policy states they will pay 100% of what they allow. If they allow \$150.00 the remaining \$30.00 is the parent's balance.

### **Fact 2 — INSURANCE BENEFITS ARE NOT DETERMINED BY OUR OFFICE**

Your insurance benefit is determined by the type of plan selected by your employer. We have no input on what your insurance pays for procedures. Insurance companies set their own fee schedules, and each insurance company has a different set of fees and guidelines.

### **Fact 3 — Deductible**

When estimating your dental insurance, benefits make sure to consider your deductible. Each insurance company has a different deductible amount. You have to meet your deductible amount before most insurance companies will pay for any treatment.