

**JOHNSON ORAL SURGERY
PATIENT REGISTRATION**

NAME _____ DATE OF BIRTH _____ SS# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HM PHONE _____ WK PHONE _____ CELL _____
EMPLOYER _____ EMAIL ADDRESS _____
IF UNDER 18 - PARENT OR RESPONSIBLE PARTY _____

DENTAL INSURANCE: _____

POLICY HOLDER _____ SELF PARENT SPOUSE
DATE OF BIRTH _____ SS# _____ EMPLOYER _____

MEDICAL INSURANCE: _____

POLICY HOLDER _____ SELF PARENT SPOUSE
DATE OF BIRTH _____ SS# _____ EMPLOYER _____

SECONDARY INSURANCE, IF ANY _____ **MEDICARE RECIPIENT** YES NO

REFERRED BY _____ **DENTIST** _____

PRIMARY PHYSICIAN _____ **ORTHODONTIST** _____

HOW DID YOU CHOOSE OUR OFFICE- REFERRAL LOCATION INSURANCE RELATIVE/FRIEND INTERNET

CONTRACT TO PAY FOR MEDICAL SERVICES

In consideration of professional services provided to the above patient, I/we agree to pay your reasonable and customary rates for these services in full, at the time of service, unless other arrangements have been made in advance. I/we authorize Dr. Matthew Johnson to receive assignment of insurance payments. **If the customary charges are more than the benefits allowed under the responsible party's insurance plan, I/we agree to pay the difference.** I understand that a finance charge of 11% will be added to my outstanding balance after 60 days.

AUTHORIZATION TO RELEASE INFORMATION

Dr. Matthew Johnson is hereby authorized to release any medical or incidental information that may be necessary either for medical care or for processing requests of financial benefits.

LEGAL RESPONSIBLE PARTY

If the patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. **By signing this form, you agree that you have been given and have had the opportunity to read our Notice of Privacy Practices.**

Patient Signature

Date

Responsible Party Signature

Date

BUSINESS POLICY FOR JOHNSON ORAL SURGERY

PLEASE READ THE FOLLOWING BUSINESS POLICY CAREFULLY

The primary goal in this office is to provide you, the patient, with state of the art oral surgery treatment. At the same time, we hope to make this experience as pleasant and as comfortable as possible. We must, however, establish a strict business policy so that we can concentrate on your medical and dental care while keeping our administrative costs at a minimum.

At the time of your visit to our office, we will make every effort to provide you with the most accurate financial assessment of your specific treatment needs. It is sometimes impossible to anticipate every procedure in advance. Therefore, there may be some differences in what is expected before surgery and the final outcome. Again, we will make every effort to **ESTIMATE**, as close as possible, your specific treatment costs.

If you have medical and/or dental insurance, you must provide us with complete, current, information in order for us to file the insurance claim for you. We will contact your insurance carrier to verify eligibility, benefits, and copays. Please note that our office is not responsible for any incorrect information that is given to us by your insurance company – it is your responsibility (and to your advantage) to know your own insurance. Once we have verified your insurance, we will **ESTIMATE, as accurately as possible, your portion that will be due at the time of service. In the event that the insurance company does not pay what we had anticipated, **YOU WILL ULTIMATELY BE RESPONSIBLE FOR ANY OUTSTANDING BALANCE**. On the other hand, if the insurance company pays more than what we had anticipated, you will be due a refund. Refunds are issued once a month and should be expected in the mail within the last two weeks of the month.**

If you do not have any insurance coverage, we expect payment, **in full**, for any services rendered that day. If you are unable to pay for your treatment costs, we do offer two finance options available through Wells Fargo Financial. Applications can be taken over the phone and approval can be obtained the same day. For your convenience, we accept cash, check, and all major credit cards as forms of payment. Please note that there will be a \$25.00 service fee applied to any and all checks returned from your bank unpaid. Payment, **in full**, for the bounced check and service fee is expected immediately upon your receipt of the bank's notice of the returned check. **No partial payments will be accepted.**

When your insurance has made payment and there is still a balance left on your account, you will receive a statement and payment will be expected in 30 days or less. Once your account balance goes over 120 days, it will be turned over to our collection agency. **In this unlikely event, you will be responsible for any and all fees that our office incurs throughout the collection process.** The collection agency can charge up to 40% of whatever is collected on the account and we can charge up to a 2% finance charge on the outstanding balance. These charges will automatically be added to your account.

FOR MEDICAL INSURANCE CLAIMS

If your medical insurance requires a referral from your primary care physician (PCP) to be examined and treated by a specialist, it is your responsibility to obtain that referral from your PCP. If your dentist refers you to our office for a medical condition that we will be billing to your medical carrier, you must contact your PCP before your visit to our office and go through the referral process. In the event that you come to this office unaware of needing a referral from your PCP, we will attempt to help in any way to obtain that referral for you. Please note that we cannot guarantee we will be able to get the referral. Any claims that are denied because there was no referral from the PCP on file with the medical insurance carrier will be the responsibility of the patient.

FOR DENTAL INSURANCE CLAIMS

Dental insurance carriers do not require that you have a referral from a primary care physician. If you are being treated for a dental condition, it is not necessary to obtain any referrals for billing claims to your dental carrier.

PATHOLGY CLAIMS

For those patients having lesions removed - specimens are taken to Lake Norman Pathology Associates or LabCorp for diagnostic examination. Any charges associated with the services at Lake Norman Pathology or LabCorp are the responsibility of the patient.

By signing this business policy, I verify that I have read carefully, completely understand, and fully agree to adhere to all the terms outlined above.

Signature _____

Date _____