AZALEA ROAD DENTAL
DR. RONALD HARRELL

Registration Information

Patient Name:_____Preferred Name: _____
Last First MI

☐ Male ☐Female ☐ Married ☐ Single ☐ Child ☐Other

Social Security #:_____Birth Date:_____Driver's License:_____State:_____

Phone (Home):_____(Work):_____Ext:_____(Cell):_____

E-Mail Address:_____Would you like text/email reminders? ☐ Yes ☐ No

Home Address:_____
Street City State Zip

Employer Name:_____Emergency Contact Name and Phone: _____

How did you hear about our office?_____

Insurance Information

Primary Insurance Policy

Name of Policy Holder:_____Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth:_____Policy Holder's ID#_____Group # _____

Policy Holder's Employer:_____Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Insurance Company Name:_____Phone #: _____

Secondary Insurance Policy

Name of Policy Holder:_____Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth:_____Policy Holder's ID#_____Group # _____

Policy Holder's Employer:_____Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Insurance Company Name:_____Phone #: _____

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company; however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefit: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Dr Ronald Harrell of the insurance benefits otherwise payable to me.

X Signature of patient, parent or guardian:_____Date: _____

TEXT MESSAGE TO MOBILE AND EMAIL CONSENT

- ○ I consent and accept the risk in receiving information via text/email.
- ○ I do not want to receive information via text/email.

PURPOSE: This form is used to obtain your consent to communicate with you by text/email regarding your Protected Health Information. Azalea Road Dental, Dr. Ronald M Harrell offers patients the opportunity to communicate by text/email. Transmitting patient information by text/email has a number of risks that patients should consider before granting consent to use text/email for these purposes. Azalea Road Dental, Dr. Ronald M Harrell will use reasonable means to protect the security and confidentiality of email information sent and received. However, Azalea Road Dental, Dr. Ronald M Harrell cannot guarantee the security and confidentiality of text/email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of text/email between Azalea Road Dental, Dr. Ronald M Harrell and myself, and consent to the conditions outlined herein. Any questions I may have, have been answered by Azalea Road Dental, Dr. Ronald M Harrell.

Patients Signature: _____ Date: _____

Appointment Policy

We require 48 hours' notice for appointment cancellations. Appointment changes without adequate notice may be subject to a fee of up to $75.00, payable by the patient and not the insurance company.

_____Patients Initials

Billing Policy, Consent for Treatment and Payment

Payment is expected at time of service. We accept cash, check, Visa, Discover, MasterCard and CareCredit. Returned checks are subject to a $30.00 fee. Aged balances over 60 days, regardless of insurance, are subject to a billing charge of $2.00 per month and/or finance charges of 21.0% A.P.R. Balances not paid within ten days of the due date are subject to a late fee of 5% or $15.00 per service date. A past due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 60 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:
I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

X Signature:_____ Date:_____

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA)

You may refuse to sign this acknowledgement.

I,_____, have received a copy of this office's Notice of Privacy Practices and consent to the healthcare operations it describes.

Print the Name of the Patient or Personal Representative: _____

X Signature of Patient or Personal Representative:_____Relationship to Patient:_____