THE LOOP ENDODONTICS

Lina Cortes, DDS
Endodontist

Patient Information

Patient Name:_____ Email:_____

Male or Female: SS# ___-___-____ DOB:___/___/____

Address:_____
Street City State Zip

Main Phone #: (____)____-____ Secondary Phone # :(____) ____-____

(Circle One): Married Single Divorced Widowed
Name of Spouse or Guardian:_____

In Case of Emergency:

Whom may we contact in the case of an emergency?: _____
Name
Phone# : (____) ____-____ Relationship to Patient: _____

Primary Policyholder Information:

Name:_____ Phone #: (____)____-____

Male or Female: SS# ___-___-____ DOB:___/___/____

Address:_____
Street City State Zip

Employer:_____ Employer Phone #: (____)____-____

Employer Address:_____
Street City State Zip

Insurance Carrier:_____ Insurance Phone #: (____)____-____
Subscriber/Member ID #_____ Group#_____

Authorization

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have also read and fully understand all the information on this form and have completed the above answers. I therefore, certify this information is true and correct to the best of my knowledge. If any changes occur with my health status or the above information I will notify The Loop Endodontics. I authorize the release of any information relating to this claim. I hereby authorize payment directly to The Loop Endodontics or the group insurance benefits otherwise payable to me.

Signature:_____ Date:_____
- Patient or Guardian

The Loop Endodontics
1106 Cypress Glen Circle, Kissimmee, Fl. 34741
Email: info@theloopendo.com
Office: (407) 627-0424

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Medical History

Patient Name: _____ DOB: ____/____/____

Date of your last dental care exam: _____

Are you under a physician's care now? YES_____ NO _____
If yes, please explain: _____

Are you currently taking any medications? YES _____ NO _____
If yes, please explain: _____

Women: Are you…
Pregnant? YES _____ NO _____ If yes, how many months? _____
Nursing? YES _____ NO _____ Taking oral contraceptives? YES _____ NO _____

Are you allergic to any of the following? Please circle: *Aspirin, Penicillin, Codeine Darvon, Valium Percodan, Local Anesthetics, Erythromycin, Nitrous Oxide,* Other:_____

Circle any if you have or you have had any of the following:

AIDS/HIV Positive	Chest Pain	Heart Murmur	Lupus
Anemia	Cold Sores	Heart Pacemaker	Mitral Valve Prolapse
Angina	Fever Blister	Hepatitis A	Psychiatric Care
Arthritis / Gout	Congenital Heat Disorder	Hepatitis B or C	Recent Weight Loss
Artificial Heart Valve	Convulsions	Herpes	Rheumatic Fever
Artificial Joint	Diabetes	High Blood Pressure	Sinus trouble
Asthma	Drug Addiction	Hypoglycemia	Stroke
Blood Disease	Epilepsy / Seizures	Irregular Heartbeat	Thyroid Disease
Breathing Problem	Excessive Bleeding	Kidney Problem	Tuberculosis
Cancer	Hay Fever	Leukemia	Tumor
Chemotherapy	Heart Attack / Failure	Liver Disease	Venereal Disease

Have you ever had a serious illness not listed above? YES_____ NO _____
If yes, please explain:_____

To the best of my knowledge, the question 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 Loop Endodontics of any changes in medical status.

Signature: _____ Date: _____
(Patient or Guardian)

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Patient Financial Responsibility Disclosure and Acknowledgment

Thank you for choosing The Loop Endodontics as your dental provider. We are committed to your treatment being successful. Your signature on the line below forms a legally binding agreement between The Loop Endodontics and the undersigned patient (the "Patient") who is receiving dental care, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of dental bills associated with the dental services provided by the Loop Endodontics, and is the individual indicated on the form below as the Responsible Party in the space provided. The patient, if over the age of 18 years of age is the Responsible Party. The following is a statement of our payment policy. This payment policy applies to all services provided by The Loop Endodontics regardless of the location.

All charges for services rendered are due and payable at the time of service.

For our Patients with Dental Insurance Benefits:

The providers of The Loop Endodontics participate in most major dental plans and will verify eligibility and coverage for all insurances. Our business office will submit a claim for any services rendered to a patient; however, it is the Responsible Party's responsibility to pay the entire amount of all services rendered. It is the Responsible Party's responsibility to provide all necessary information and complete any required forms before leaving the office. The Loop Endodontics will not pursue secondary insurance coverage. That is your responsibility as the patient. Please contact your insurance company with any questions about your insurances coverage.

In addition, your insurance company may be based on fees considered "usual and customary" that differs from ours. We change what is usual and customary for our practice. ***You are responsible for payment in full regardless of your insurance company's arbitrary determination of "usual and customary" rates.***

Please remember that insurance is a contract between you and insurance company. Our office is not part of this contract. ***You are responsible for the timely payment of your account.*** We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under terms of our contract with various health plans. Payment of co-payments and co-insurance are due at the time of the office visit.

Any remaining balance on your account after the insurance company has processed your clam and sent the Explanation of Benefits is due and owing within 30 days of receiving a statement from our office. Failure to pay all unpaid balances within 30 days of receiving a statement from our office will result in a billing fee of $15 to cover the cost of a statement being sent to you.

For our Patients with no Dental Insurance Benefits:

If you do not have dental insurance, payment for all professional services is expected at the time of your visit.

Name:_____ **Signature:**_____ **Date:**_____
(Patient or Guardian) (Patient or Guardian)

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Office Policy

Missed Appointments:
Failure to give a 24-hour notice of an appointment or not showing up for an appointment will result in a charge of $100 on your account. This charge cannot be billed to the insurance company and will be your responsibility. Failure to pay a no-show fee will be treated according to our policy on unpaid balances, with the exception of collection notices. A 24-hour notice is required to change a scheduled appointment.

Methods of Payment:
Cash, personal check (with valid ID), Visa, MasterCard, American Express, and Care Credit. Charge backs are considered theft of retail services via the act of conversion. This offense is handled by the local police department and settled through prosecution by the state attorney's office. All fees associated with prosecution will be accepted by the undersigned.

Returned Check Policy:
If a payment is made on an account by check and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or Responsible Party will be responsible for the original check amount in addition to a Service Charge allowed by Florida Statute. The Loop Endodontics will notify the responsible party by mail in the event that a check is returned and shall in such notice provide fifteen (15) days from the date of the notice for repayment by the Responsible Party of the face amount of the check plus the Service Charge. If payment of the face amount of the check plus the Service Charge is not received by The Loop Endodontics within the applicable 15-day time period, then The Loop Endodontics may return the account over to a collection agency for collection of the same.

The Responsible Party shall be responsible for all costs of collection, which shall include a collection fee that will be added to the outstanding balance – in addition to the face amount of the check and Service Charge.

The Responsible Party may also be subject to civil charges pursuant to the Florida Bad Check Statute, which among other things, may result in the Responsible Party being held liable for damages which may equal to three (3) times the face amount of the bad check, plus statutory charges permitted by law.

Past Due Accounts:
In the event that The Loop Endodontics should initiate collection proceedings or other legal action to collect an overdue account, the Responsible party acknowledges and understands that The Loop Endodontics has the right to and shall disclose t its outside collections agency all relevant personal and account information necessary to collect payment for services radared, including any applicable Service Charges and applicable costs of collections. The Responsible Party understands and acknowledges responsibility for all costs of collections, including without limitations Attorneys' fees and costs, court costs, and the interest shall accrue on all unpaid balances at the rate of 1 ½ % per month (18% per annum).

Please be advised that if a balance remains unpaid, the patient may be discharged from The Loop Endodontics. We hold the right to refuse to see a patient who has an unpaid balance.

By Signing below, you agree to accept full responsibility as a patient who is receiving dental services, or as the Responsible Party, as applicable. Your signature below verifies that you have read the above disclosures, understand your responsibilities, and agree to the terms set forth herein.

Patient Name: _____ Responsible Party :_____
Patient Signature:_____ Responsible Signature:_____
Date:_____ Date:_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below 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 and I understand that 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: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered in this acknowledgement:

_____ _____

_____ _____

**********For Office Use Only**********

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reasons.

- The patient refused to sign
- Communication Barrier
- Emergency Situation

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