CONFIDENTSMILES
OF LAURENS
CHANGING LIVES ONE SMILE AT A TIME

PATIENT NAME:_____ DOB:_____

ADDRESS:_____

_____

SSN#:_____

CELL#:_____ HOME/WORK#: _____

EMAIL: _____

PARENT/SPOUSE NAME _____ DOB:_____

- ☐ Yes, I authorize CSL to contact me via email, text, phone, and paper mail about my appointment information, financial information, family billing information, and clinical information.
- ☐ No, I do authorize CSL to contact me via email or text. I would like to be contacted by phone or paper mail only.

Due to HIPPA laws we need written consent to give out appointment information, financial information, family billing information, and clinical information to anyone other than the patient/parent. The following people are authorized to receive any of the above information IN PERSON WITH identification:

- ☐ _____ Relationship: _____
- ☐ _____ Relationship: _____

PRIMARY INSURANCE:

SUBSCRIBER Name _____ DOB _____

Employer _____

Dental Insurance Company _____

Insurance Address _____

Insurance Phone# _____ ID#OR SSN_____

SECONDARY INSURANCE:

SUBSCRIBER Name _____ DOB _____

Employer _____

Dental Insurance Company _____

Insurance Address _____

Insurance Phone# _____ ID#OR SSN_____

*Confident Smiles of Laurens Fine Print - *Please Initial on The Line**

Rights of the Patient

_____ I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form
I understand that a revocation is not effective in cases where the information has already been used or 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.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

Cancellations & Failed Appointments

_____ As a patient in our clinic, it is your responsibility to keep scheduled appointments. Confident Smiles of Laurens requires notification of cancellation at least 48 hours prior to the scheduled appointment time. CSL will consider it a "failed appointment" any time a patient has not given the advanced notice required above or fails to arrive within 10 minutes of their scheduled appointment time. If you do not confirm within 48 hours, CSL reserves the right to offer the time to another patient.

_____ Failure to give a 48 hour notice will result in a **$50 charge** to your account for missed or cancelled appointments occurring more than 1 time in a calendar year. If you feel there has been an error in scheduling or believe you deserve special consideration, please let us know and you may speak with our Office Manager.

_____ **Repayment** of required amount to reserve a visit with Dr. Cost ($20 or 20%, whichever is greater) **plus $50 will be required to reschedule.**

Assignment of Benefits

____ I hereby assign all dental, medical, and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Confident Smiles of Laurens** (R. Nicholas Cost, Jr., DDS, PA). On behalf of myself and/or my dependents, I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

____ I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to **Confident Smiles of Laurens** (R. Nicholas Cost, Jr., DDS, PA) upon receipt for services rendered. I further understand that fees are due and payable for the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement or invoice.

Financial Responsibility

____ I understand that I may choose to pay via Cash, MasterCard, Visa, American Express, Discover, CareCredit, or HSA/FSA. My signature below will act as a Signature on File (SOF) authorizing credit card payments when payments are made over the phone or in the office towards my services with my verbal authorization.

____ We require either 20% down payment or $20 down (whichever is greater) of your FULL TREATMENT estimate. The remaining amount is due the day of your appointment prior to being seen. Any ESTIMATE we provide is subject to the terms and conditions of the plan your employer has chosen for you.

____ We offer financing through 3rd party entities and assist you in applying for them if you are interested. We do not offer in-house financing.

____ We offer a Dental Membership Club for additional savings for those patients without traditional dental insurance.

____ I authorize Confident Smiles of Laurens to keep this credit or debit card on file. If the balance due is within $50, CSL is authorized to immediately charge my card and send me a receipt after insurance pays. If the balance due is over $50, CSL will try to contact me to collect payment. If I have not responded within 60 days after my insurance paid or denied my claim, CSOL is authorized to charge my card for the balance due.

Card Number:_____ Expiration Date:_____ CVV:_____

X _____ **Date:**_____