3911 N Boulevard Tampa, FL 33603
(o) 813 209 0338 | (f) 813 209 0388
office@tomlinsondentalcare.com

OFFICE INSURANCE AND FINANCIAL POLICY OVERVIEW

Please initial all highlighted areas

❖ Insurance

1. _____If you have **HMO** you must verbally inform our front desk prior to treatment. I understand that Tomlinson Dental does not participate in any HMOs and that I will be responsible for full payment.
2. _____Please realize our office does not know and cannot determine your individual healthcare benefits. We will do our best to maximize coverage for your visit within accepted rules and regulations. However, knowing your benefits and financial liability is ultimately your responsibility.
3. _____**Not all services are a "covered" benefit in all insurance policies. Your policy is a contract between you and your insurance company, and NOT between Tomlinson Dental and your insurance company. You are responsible for applicable charges as per your insurance agreement (such as deductibles, percentages, co-pays, etc). SERVICES ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE.**

❖ Financial

1. _____Be aware that payment is expected at the time of service and that our office accepts cash, check ,Visa, Master Card, Discover and American Express. Affordable payment arrangements are available through Care Credit or the Lending Club. **Ask our staff for more information**.
2. _____**Deposit**: A deposit will be required to hold your reservation for major procedures.
3. _____**Check Policies:** If a check is returned for insufficient funds and/or closed account, you will be charged a $35.00 return check fee in addition to your balance owed. You will have 7 business days to make good on your check or other action will be taken.

❖ Appointment Reservation Policy

1. _____We recognize that reservations made in advance may sometimes need to be rescheduled. A minimum advance notice of 48 hours is required to reschedule your reservation. Reservations can only be rescheduled by speaking to an appointment secretary. Message left on the recorder, are not considered to be proper notification.
2. _____**Late Arrivals**: We realize that your time is valuable; therefore, patients who are not on the time for their reservation maybe rescheduled.
3. _____**Emergency Patients:** Every attempt will be made to see patients on an emergency basis in order to address their needs. Patients may have a wait time as we try to accommodate them into our regular schedule.
4. **After hours Emergencies**: Current patients of record please call us at: Cell# 813-504-2806.

_____ **Please inform our office of any insurance, address, email, or telephone changes.**

I have read and understood the above policy and I agree to meet all my obligations

_____	_____	_____
Patient Name	**Patient or Guardian Signature**	**Date**

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NEW PATIENT FORM

Today's Date:_____

Patient Name:_____

Preferred Name:_____ Preferred Pronouns: _____

Address:_____City:_____ Zip:_____

SSN_____-_____-_____ D.O.B._____/_____/_____Gender: □ F □ M □ N

Marital Status: □S □M □Other Email: _____@_____.com

Phone #s:(c)_____(w)_____ (h)_____

Name of person responsible for payment for services: _____

How did you hear about us? _____

Student: □ Y □ N If so, what school:_____

Reason for Appointment: _____

_____

Insurance Information:

Insurance Company:_____

Subscriber Name:_____ Subscriber D.O.B:____/____/_____

Subscriber SSN_____-_____-_____ Member ID#:_____

Employer: _____Group#:_____

Insurance Phone #:_____

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HIPAA PATIENT QUESTIONNAIRE

1. Please list the family members or other person(s), if any , whom we may inform about your general medical condition and your diagnosis (including treatment ,payment and health care operations) :

Name: _____ Phone Number: _____
Name: _____ Phone Number:_____
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

2. Please list family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name: _____ Phone Number: _____
Name: _____ Phone Number:_____
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

3. Please print the address of where you like you're billing statements and/ or correspondence from our office to be sent ***if other than your home.*** **(Confidential Communication).**

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked
"CONFIDENTIAL". ☐ Yes ☐ No

5. Please print the telephone number or email address where you want to receive calls about your appointment, lab & x-rays results or health care information ***if other than your home phone number:*** (_____)_____ Email:_____@_____.com

6. Can confidential messages (ie, appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rile of 2013.

Print Patient Name (if under 18 Years): _____

_____ _____
PATIENT or GUARDIAN SIGNATURE **DATE**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES UPDATE

You May Refuse To Sign This Acknowledgement

I, _____, have reviewed a
(Print Name)

copy of this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
But acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____