

PATIENT REGISTRATION

(Updated 9/2022)

First/Last Name: _____

EMAIL: _____ Cell #: (_____) _____

Birthdate: _____ / _____ / _____ SSN (For Acct Purposes): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Home #: _____

Whom may we thank for referring you? _____

MINORS / GUARDIAN / MEDICAL POWER OF ATTORNEY (MPOA): {complete if applicable}

A.) Person responsible for making TREATMENT decisions

Parent /Legal Guardian/MedicalPOA: _____

Relation: _____ Cell: _____ Email: _____

Parent/Guardian/MedicalPOA are to be available in person and/or by cell phone to provide consent for treatment, to schedule appointments, to avail themselves for our clinical team to discuss any updates during treatment, to receive post-operative instructions as indicated.

Hygiene only: If the responsible person allows a minor to drive to their hygiene appointment, Parent/Guardian consents to scheduled treatment and is responsible to coordinate payment or set up VAULT card to process for services rendered same day.

Medical POA: Please provide administration this supporting document to scan into the patient’s file.

B.) Person responsible for making FINANCIAL/PAYMENT decisions:

First/Last Name: _____ Relation: _____

EMAIL: _____ Cell: (_____) _____

Relation: _____ Birthdate: _____ / _____ / _____ SSN :(for accts purposes) _____

Street Address: _____

City: _____ State: _____ Zip: _____

HIPAA CONSENT

https://www.hhs.gov/hipaa

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patients consent or knowledge. Our practice has a Notice of Privacy Practices that outlines how we keep patient data safe in our administration, physical security and technical security.

Patient OVER 18 years old:

It is understood that our office will share information regarding your treatment with yourself and Drs. If you would like us to release information regarding your treatment to a loved one, should they call on your behalf, please list their names and relationships below.

Patient UNDER 18 years old:

It is understood that our office will share information regarding treatment of minors with parents and Drs. If you would like us to release information regarding this patients treatment to anyone else, should they call on your behalf, please PRINT their names and relationships below:

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____

_____ Patient Signature (Parent or Guardian if minor) _____ Printed Name _____ Date

PRIMARY DENTAL INSURANCE

All information below pertains to the POLICYHOLDER

A.) POLICYHOLDER [if SELF and skip to Section B.)]

First: _____ Last Name: _____ SSN: _____

Relation: _____ Birthdate: / / Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____

B.) Policyholder's Employer: _____

Dental Carrier Name: _____ Telephone # _____

Group#: _____ Subscriber ID# _____

AUTHORIZATION, RELEASE AND SIGNATURE ON FILE:

I am authorized and grant permission to the office of Esther Y Kim DDS PLLC or Beyond Just Smiles to:

- Communicate with me by email /text cell or home phone between 8am-9pm to discuss matters related to my care.
- Discuss diagnosis, clinical records, and treatment recommendations with referral doctors, your PCP, or other healthcare practitioners as indicated.
- Use this Signature on File to process insurance claims on my behalf, include supporting documentation to support services rendered, claim appeals and to release benefit payment for services rendered, otherwise payable to me, to the professional corporation: Esther Y Kim DDS PLLC

 Patient Signature (Parent or Guardian if minor) Printed Name Date

APPOINTMENT SCHEDULING AND CONFIRMATION PROCESS

Scheduling appointments with our Providers: Please call our Scheduling Administrator for your preventative hygiene service or restorative needs to 603-882-3001. We will be happy to find a mutually agreeable time with your preferred provider Monday thru Thursday between 8-5pm.

Our Commitment to Our Patients:

To respect your scheduled time, we do our best to plan the proper time necessary to complete your individual treatment procedures so that we can see each patient on time. There are times when factors beyond our control may present that affect our schedule and result in us falling behind in seating the next patient on time. To be respectful of your time, we will do our best to see you as close to your reserved time as possible. If we anticipate we are unable to seat you within 15 minutes of your scheduled appointment time, we will communicate this either directly, by text or calling your cellphone as soon as we are aware of the delay, offer the option of waiting to be seen as soon as your provider is available or rescheduling your appointment.

What you can expect from our office in using our automated patient communication system:

Once you have scheduled your appointment with our office, please make sure we also have your updated EMAIL and CELL phone number in our system as we utilize them with our automated appointment confirmation system. The system will initially start with a Save the Date Email and closer to your reservation it will prompt you to select CONFIRM in order to let our system know you will present. If you do not CONFIRM by this method, we will reach out personally by phone to contact you and ask you verbally contact us about your scheduled reservation with your provider.

Account Billing and Insurance Claim Services and Fees:

- ❖ **Billing Statements:** We request payment upon checkout from your services, however, there are situations where a balance billing statement may be necessary, such as filing a claim with a carrier who sends payment to our office. For efficiency and link for online payment, we email your balance billing statement. Please make the payment in full no later than the due date to avoid a late fee or finance charges. If you do not have an email on file, we will mail your billing statement so keeping those up to date is important
- ❖ **Secure Online Patient Portal:** 24/7 access thorough www.BeyondJustSmiles.com
 Establish a Virtual Account/Set-up a private username/password to facilitate access that YOU control
- ❖ **VAULT Payment:** For your convenience, we offer the service to place your credit card in a secure portal for balance billing, reoccurring monthly charges for payment agreements, or to ease your checkout process for yourself or family members.
- ❖ **BeyondJustSmiles In Office Membership Plan- No insurance, no problem, YOUR loyalty matters to us.**

- 4 packages designed to fit your unique needs and joining the membership will save you money
 - Start your annual membership anytime; payment by check is preferred.
 - Additional 10% loyalty rewards applied for restorative services paid by check or cash
 - Unlike insurance, there are no deductibles, service restrictions, limitations, or uncovered services
 - Our membership is not insurance and cannot be combined with a dental benefit plan or other offer.
- ❖ **CareCredit Financing:** a healthcare credit program offered to eligible patients by an independent company allowing for payment over time. Applications at www.carecredit.com, and we are happy to guide you or help you with this process.
- ❖ **Electronic Dental Benefit Plan Claim Service:**
- We employ a highly trained team of administrators to support our electronic claim service and are happy to provide this service as a courtesy to you. We also offer to verify your active coverage in advance of your scheduled appointment, but can only do this if you provide us with **CURRENT** Policyholder details in advance of your scheduled appointment to allow our team adequate time to download or call a carrier directly.
 - Insurance carriers receive claims from our service electronically and best practices expect adjudication along with mailing/receiving a check payment within **15** days of their receipt. Some carriers will send payment directly to you; others may send payment to our office. Regardless of your coverage, you are responsible for timely payment of services rendered.
 - We will be happy to appeal claims for you, however, we ask you to cover full payment for services rendered should the claim not be paid within 30 days or is being held up for various reasons beyond our control.
- ❖ **Service Fees:** It is important that the patient contact our Accounts Manager in a timely manner should financial obligations not be met due to temporary financial problems. A phone call to communicate directly with our Accounts Manager is part of the solution and management of your account.
- **Late Fee:** Automatically assessed \$10 when payment in full is not received by the statement due date.
 - **Finance Charge:** Automatically placed on any aged balance at 60 days at a Periodic Rate of 2% per month or 24% Annual Percentage Rate (APR) calculated from the date of service regardless of benefit plan benefits, claim status, or unfulfilled payment plans.
 - **Returned checks:** non-sufficient funds on a returned check will be assessed a minimum of \$40 to the account.
- ❖ **Past Due Accounts:** If our Accounts Manager is unable to find a solution to managing any account 90 days past due, we reserve the right to submit said account to a collection agency. This results in the addition of a 35% service charge to cover the agency fees to pursue the recovery of said outstanding balance. Submission to this outside agency results in the termination of the doctor/patient relationship for the patient and any members associated with the patient's account. Additionally, the guarantor of the account's credit rating will be under scrutiny by the 3 credit reporting bureaus.
- ❖ **Missed Appointment Fees:** We reserve the right to charge your account a missed appointment fee for missing your reserved appointment. Appointment changes or cancellations require a minimum of 2 business days' notice to avoid this fee.
- Appt with your Registered Dental Hygienist will incur a \$120/ hour fee.
 - Appointment with Dr. Bobbitt will incur a \$300/hour fee.
 - Appointment with your dental assistant for post-operative/services will incur an \$80/ hour fee.
 - Any prepayment courtesies will be rescinded for multiple appointment restoration cases.

IMPORTANT INFORMATION ABOUT OUR PRACTICE'S CULTURE ON FINANCE AND INSURANCE

Contact: Accounts@BeyondJustSmiles.com T: 603-882-3001

We are committed to providing you with the finest care available at a reasonable cost. To keep our office running smoothly, we ask payment be made at the time of service by check, cash, debit card, Health Saving Card, Flex Spending Card, Visa, MasterCard, Discover, American Express, Apple Pay or Care Credit.

Should you like to discuss setting up your VAULT card, payment plan options, CareCredit application, membership plans, prepayment options, please contact our Accounts Manager in advance of your scheduled appointment so we have the time to look at options to help you plan or answer questions you may have in a timely fashion. When financial arrangements are made in advance or your carrier changes how they pay to our office and pays you directly, we may have to balance bill you. We send a monthly statement, please call our office if your statement does not reflect your insurance payment within the 15-30 days of services rendered. Any remaining balance after your insurance has paid will be your responsibility. Your prompt remittance is appreciated. We realize temporary problems may affect the timely payment of your account. If such problems do arise, we encourage you to call the office promptly for assistance in the management of your account.

Please make us aware of any changes to your name, address, email, cell phone number, or policyholder changes so we can communicate effectively with you. If you have questions about your account, please call 603-882-3001 or email Accounts@BeyondJustSmiles.com, we are here to help in any way we can.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance, please be aware that not all services are a covered benefit in an insurance contract. Insurance companies differ in their policies regarding coverage of procedures or services a doctor may provide. They may arbitrarily select certain services they will not cover and each policy is negotiated differently with different premiums paid and coverages associated with your specific policy. Your plan may require you, as the policyholder to pay nothing, a deductible, or a portion of the fee or it may require you pay for the entire procedure. We will do our best to give you an educated guesstimate for your coverage but will not know the outcome until your claim is adjudicated.

We choose not to participate in managed care/PPO/dental service contracts as we feel it will not allow us to provide the level of care and service that our colleagues and patients have come to expect of us and that we demand of ourselves. Some plans with “out of network” benefits will reimburse you for a portion of your total cost or send payment to our office accordingly.

Your insurance is a contract between you, your employer if not a self-insured plan, and your insurance company. We are not party to your contract, therefore, we must emphasize that our relationship is with you, the patient, not with your dental benefits carrier. While the filing of insurance claims is a courtesy that we extend to our patients, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

We are happy to send pre-treatment estimates for major services on your request to help you plan. Any pre-treatment estimate is not a guarantee of coverage, but a guide to what your carrier may consider when adjudicating your claim. Factors that can inhibit coverages are covered service, maximums, deductibles, pending claims on coverage that may not have been active at the time of inquiry. Any treatment claimed from our or other offices will reduce your remaining benefits offered by your dental benefits carrier.

We appreciate the opportunity to care of you, if you have any questions about the above information or any uncertainty regarding a treatment plan or insurance. Please do not hesitate to ask us, we are here to help or guide you to the best of our ability.

I have read the above Appointment Scheduling, Account/Billing/Insurance Claim Services and Important Information about our Practice Culture on Finance and Insurance above.



Patient Signature (Parent or Guardian if minor)

Printed Name

Date

Notes: