BeyondJustSmiles.com Dr. Esther Kim

PATIENT REGISTRATION

First/Last Name: _____

EMAIL: _____ Phone #: ( )

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

Street Address: _____

City: _____ State: Zip:

Whom may we thank for referring you? _____

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

A.) Person responsible for making TREATMENT decisions: _____

Relation: _____ Phone: 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. Please provide administration with Medical POA documentation.

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

First/Last Name: _____ Relation:

EMAIL: _____ Phone # ( )

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

Street Address: _____

City: _____ State: Zip:

DENTAL INSURANCE - All information below pertains to the POLICYHOLDER

First: Last Name: SSN:

Relation: Birthdate: / / Employer:

Street Address: _____

City: _____ State: Zip:

Dental Carrier Name: _____ Insurance phone #

Group#: Subscriber ID#

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 Dr. 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 Dr. 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:

Person: _____ Relationship to Patient:

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

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

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

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 Please make the payment in full no later than the due date to avoid a late fee or finance charges.

- **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.
- **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.
- **Returned checks:** non-sufficient funds on a returned check will be assessed a minimum of $40 to the account.

❖ **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.

❖**Beyond Just Smiles In Office Membership Plan-** Please see current brochure for details

❖**3rd Party Financing:** available, interest rate is based on credit score.

❖**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.
- Regardless of your coverage, you are responsible for timely payment of services rendered.

❖ **Missed Appointment Fees:** We reserve the right to charge you a $100 missed appointment fee for missing your reserved appointment. Changes or cancellations require a minimum of 2 business days' notice to avoid this fee.

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

We are committed to providing you with the finest care available at a reasonable cost. 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 3rd party financing approved prior to appointment. Financial arrangements MUST be made in advance of your appointment. Any remaining balance after your insurance has paid will be your responsibility. Your prompt remittance is appreciated. 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 we can. Your insurance is a contract between you, your employer if not a self-insured plan, and your insurance company. We are considered out of network with insurances, 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 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.

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