Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL

Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which **we require you to read and sign prior to treatment**. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment on the day services are rendered, prior to treatment. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions); therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment. After a statement of accounts has been sent and a balance is left on the account after 60 days, the credit card kept on file will be charged for any balance over 60 days. Also, a finance charge of 18% will be applied to all unpaid, past due balances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid.

MISSED APPOINTMENTS

We respectfully ask that you give us a minimum of 24 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments. A missed appointment fee of **$50** will be charged if you cancel or miss an appointment with less than 24 hours notice.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance company will allow it). I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due. I understand that there will be a duplication fee of $50 to obtain copies of my x-rays.

COLLECTIONS: Accounts 90 days past due will be turned over to our collection agency. Collection accounts will be assessed a $50 processing fee AND an additional percentage, as charged by the collection agency (percentage charged will be dependent on state laws in effect at the time).

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Signature of patient, parent or guardian	Relationship to patient	Date

C. Aydin Cabi, D.D.S. (330) 562-1644

AUTHORIZATION & RELEASE

PAYMENT OPTIONS

PLEASE CHOOSE ONE:

☐ *I will be paying my **estimated co-pay and any applicable deductible only** at the time of treatment and my credit card will be kept on file.* ***I hereby authorized C. Aydin Cabi, D.D.S. to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 60 days. C. Aydin Cabi, D.D.S. agrees to make every reasonable effort to advise me before this transaction is made.***

_____
Cardholder's Signature

_____
Cardholder's Address (street)

_____
Cardholder's Address (city, state and zip code)

_____
Cardholder's Telephone #

[] MasterCard [] Visa [] Discover [] Care Credit

Credit Card Account _____(CV Code) _____

_____/_____
Exp. Date

OR

☐ *I will be paying in full at time of service by one of the following (please check one):*

____ CASH

____ CHECK

____ CREDIT CARD

____ 3rd PARTY FINANCING

C. Aydin Cabi, DDS, Inc.

Family & Cosmetic Dentistry

Adult Patient Information Form

First Name _____ Last Name _____ Middle Initial _____

Patient is ❑ Policy Holder I prefer to be called _____

❑ Responsible Party

RESPONSIBLE PARTY (if someone other than the patient):

First Name _____ Last Name _____ Middle Initial _____

Address _____ Address 2 _____

City, State, Zip _____ Pager _____

Home Phone _____ Work Phone _____, Ext. _____ Cellular _____

Birth Date _____ Soc. Sec. # _____

❑ Responsible Party is also a Policy Holder for Patient ❑ Primary Insurance Policy Holder ❑ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address _____ Address 2 _____

City, State, Zip _____ Pager _____

Home Phone _____ Work Phone _____, Ext. _____ Cellular _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Birth Date _____ Age _____ Soc. Sec. # _____

E-mail _____ ❑ I would like to receive correspondences via e-mail.

SECTION 2

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired

Student Status: ❑ Full Time ❑ Part Time

SECTION 3 Cell Phone/Pager _____

Emergency Contact _____ Phone _____

Alternate Address _____

I was referred to Dr. Cabi by: ❑ Direct Mailer ❑ Local Paper ❑ Yellow Pages ❑ Dental Society

❑ Other _____ ❑ Dentist _____ ❑ Friend _____

Payment Method: (Payment is due in full at the time of treatment)

❑ Cash ❑ Check ❑ Credit Card ❑ Dental Insurance

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec. # _____ Insured Birth Date _____

Employer _____ Ins. Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State Zip _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec. # _____ Insured Birth date _____

Employer _____ Ins. Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $5 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jeannie Cabi Address: 485 North Aurora Road, Aurora, OH 44202
Telephone: 330-562-1644 Fax: 330-995-5233 Email: accounts@cabidds.com

C. Aydin Cabi, DDS, Inc.
Family & Cosmetic
Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this
{PLEASE PRINT NAME}

office' s Notice of Privacy Practices.

{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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify) _____

_____

_____