PATIENT INFORMATION

Name: _____ Birthdate: _____

Telephone: _____ Work: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Spouse's Name: _____

SSN: _____ E-mail Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

If patient is a minor, who is legally responsible? Please list the name, complete address and phone number:

_____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of primary insurance: _____ Group Number: _____

Employer: _____ Insurance Address: _____

Phone Number: _____ Employee/Subscriber: _____

SSN: _____ Birthdate: _____ Relationship to Employee: _____

Full-time Student? _____ Name of School: _____ City: _____

Is the patient covered by a secondary dental plan? ____ Name of Carrier: _____ Group #: _____

Insurance address: _____ Phone Number: _____

Employee/Subscriber: _____ SSN: _____ Birthdate: _____

Employer: _____ Relationship to Employee: _____

A service charge of 1 ½% per month (18% annual rate) will be applied to balances over 90 days. $1.00 minimum charge.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment as deemed necessary to be performed in our office or until written notice is given discounting this permission.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr Stacy J. Moon.

Signature Required: _____ Date: _____

Your answers are for our records only and will be kept confidential in accordance with applicable laws.

FINANCIAL INFORMATION

We offer several financial options for your convenience. Knowing this ahead of time allows us both to arrange for the completion of necessary treatment. After reviewing the following information if you have any questions please contact Heather or Jennifer for further assistance.

I give consent to the office of Moon Creek Dental to use my cell phone number listed on the patient information sheet to (choose one or both) □ call or □ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. _____ inital

- **Non-insured Patients-** For our non-insured patients we will be happy to give a 10% discount at the time of service. In addition to cash or check we gladly accept the following forms of payment: Visa, MasterCard, Discover, American Express, and Debit Cards.
- **Care Credit-** This offers you the ability to make flexible monthly payments, with interest-free options. All applications are sent through GE Card Corp and require approval.
- **Finance Charges and Late Payment Fees-** A finance charge of 18% annually will be applied to all accounts with balances over 30 days.

We reserve the right to charge a $50.00 no show fee on all accounts for appointments that are not cancelled with the required 24 hour cancellation policy.

All amounts not covered by dental insurance are due in full at the time services are rendered. I/We agree to pay all attorneys fees, court costs, filing fees and all collection costs, up to 25% of the amount owing which may be assessed by any collection agency retained to pursue the matter.

_____ _____

Patient Signature Date

_____ _____

Witness Date

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.\
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Stacy J. Moon, DDS
4266 N. Eagle Road
Boise, Idaho 83713
208-939-7053

AUTHORIZATION FOR RELEASE OF INFORMATION

Patients Name_____
Last Name First Middle

_____
Maiden Name Previously Married Name Date of Birth

I hereby request and authorize:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

To send a copy of the following reports from the patient's record:

X-ray's Perio Charting Full Dental Records

To be released to:

Dr. Stacy Moon, D.D.S.
4266 N. Eagle Road
Boise, Idaho 83713
(208) 939-7053-p
(208)938-6032-f
Email: mooncreekdental@gmail.com

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law that is applicable to ANY and ALL of the above.

My signature below authorizes release of all such information:

_____ _____
Signature of patient or responsible party Date

_____
Witness