PATIENT REGISTRATION FORM

DATE:

PATIENT INFORMATION:

Name: _____

Address: _____

City/Town, State, Zip: _____

DOB: _____ SSN: _____

Contact number: _____ Email address: _____

Gender: _____ Marital Status: _____

Occupation: _____ Employer: _____

Referring Doctor: _____

Reason for Visit: _____

Emergency Contact Name and Contact Number: _____

_____

INSURANCE INFORMATION:

Primary Insurance Company:

_____

Member ID

_____

Group #

_____

Policy Holder Name

_____

DOB SSN

_____

Relationship to Insured

_____

Employer Name, Address and Contact Number

_____

_____

Insurance Address and Contact Number

_____

Informed Consent and HIPAA Acknowledgement

TRU Periodontics & Dental Implants 912 Courtyard Dr Hillsborough, NJ 08844
Phone: (908) 304-9601
Email: info@truperio.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT

The HIPAA Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related to health care services.

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are invited in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

This notice was published and becomes effective on/before April 14, 2003.

Signature below is acknowledgement that you received this Notice of our Privacy Practices:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature: Date:

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: Relationship to Patient:

Financial Agreement

Payment is expected at the time of service. Please see one of the front desk staff to assist you.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. Pre-authorizations are not an absolute agreement by your insurance carrier to pay the amount shown. It is an estimation of benefits (EOB) only. This is clearly stated on the form the insurance carrier sends you. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

We will send out your insurance forms within a timely manner. We do not charge any additional fee to fill out these forms and do so as a courtesy. Your signature below will act as your signature on file granting your permission to submit insurance claims on your behalf.

When all insurance claims have been paid, any outstanding balance is your financial responsibility. Insurance companies may also send insurance payments directly to your address. It is your responsibility to notify the office and send when received.

We will provide you with a treatment plan for procedures to be done. A copy will be given to you at your request and one will remain in your chart. We ask that you sign this document. This I not an obligation to do the treatment.

I request that payment of authorized Health Insurance benefits be made to Dr. Amin or any of its individual physician members for any services furnished to me by TRU Periodontics & Dental Implants or any of its individual physician providers.
_____Initials

PATIENT ACKNOWLEDGEMENT:

I attest that all information provided to TRU Periodontics is accurate. If any information changes, I will inform the office.
_____Initials
I authorize TRU Periodontics release all medical information necessary for processing insurance claims to the insurers on file. I agree these provisions will be in effect until otherwise revoked by me.
_____ Initials
Thank you for understanding our OFFICE FINANCIAL POLICY. I have read this document and agree to the OFFICE FINANCIAL POLICY.

Signature: Date:

TRU PERIODONTICS
& DENTAL IMPLANTS

912 Courtyard Dr
Hillsborough, NJ 08844
www.truperio.com

Consent to Dental Photography

I, _____, hereby authorize TRU Periodontics & Dental Implants to take photographs and/or videos of my face, jaws and teeth before, during and after treatment.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I consent to allow the photographs to be used for the following:

___ Dental Records, dental research, dental communication and dental education including study clubs

___ Marketing material including websites, printed materials, and patient education

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: _____ Date: _____

Parent/Guardian (for minors): _____

Witness: _____ Date: _____