

James D. Lund, D.D.S.

Exceptional Cosmetic and General Dentistry for the entire family.

Welcome! Thank you for choosing our dental office for your dental needs. We look forward to providing you quality care in a relaxing atmosphere!

PATIENT INFORMATION

Patient Name _____ Preferred Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
_____ Male _____ Female Social Security Number _____
Phone #'s Home: _____ Cell: _____ Work: _____ Daytime: _____
If patient is a minor, legal guardian? _____
Who may we thank for referring you to our office? _____

FINANCIALLY RESPONSIBLE INFORMATION

Name _____ Marital Status _____
Complete Address _____
Home Phone: _____ Cell Phone: _____ Daytime Phone: _____
Date of birth _____ Social Security Number _____
Employer _____ Occupation _____
Work Phone _____ Relation to patient _____
E-mail address _____ D.L. No. _____
Spouse/Significant other _____
Date of birth _____ Social Security Number _____
Employer _____ Occupation _____
Work Phone _____ Relation to patient _____
E-mail address _____ D.L. No. _____

EMERGENCY / ALTERNATE CONTACT INFORMATION

Name of nearest relative not living with you _____
Address _____ Home Phone _____

I acknowledge that I have read and received a copy of the "Office Privacy Policies and Procedures" for MD Dental of Utah. I also acknowledge that my questions have been answered to my satisfaction. I understand that if I have questions or concerns I may contact the HIPAA Officer: Dr. James D. Lund at (801) 254-7777.

Name (please print) _____ Date _____
Signature _____
MD Dental of Utah Witness _____

MD Dental of Utah • 10430 South 2700 West • South Jordan, Utah 84095 • (801) 254-7777

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Financial Information

- Payment is due at time of service. As a condition of treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are rendered.
- Estimated fees are extended for a period of Three (3) months from the date of the patient examination.
- As a courtesy to all guests we extend the use of our outside billing service, which offers a wide variety of interest-deferred payment options as well as long-term payment plans.
- Due to the complexity of insurance contents, estimated amount(s) is/are not a guarantee of insurance, or patient payment. Insurance benefits may be subject to, but not limited to, eligibility, plan maximums and limitations, and insurance fee schedules. Any account balance over Sixty (60) days will be subject to a 21% annual (1.75% monthly) service charge.
- There is a \$20.00 service charge for checks that are returned unpaid.
- Patient, or financially responsible person(s), agrees to be responsible for the remaining balance plus attorney fees, court costs and a collection agency and/or attorney. In addition to these named fees, a collection fee of up to 50% may also be charged to any unpaid balance.
- This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality care, are null and void.

RESERVATION / APPOINTMENT INFORMATION

- I grant my permission to James D. Lund, DDS or his assignee to telephone me at home or at my workplace to discuss matters related to this form or concerning appointments. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.
- I authorize James D. Lund, DDS, or his assignees to release financial information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.
- We make every possible effort to get each guest in to see a doctor and/or his associates/assistants/hygienists in a timely manner. To assist us in staying on schedule we appreciate respect for prompt arrival of your reservation time.
- I understand there is a \$68 fee for missed or canceled appointments with less than 24-hour notice.

Thank you for reviewing this important information and respecting our business procedures. Our dental team is available Tuesday through Friday to answer any questions you may have about your account, scheduling a reservation, or just to chat. We will do everything in our power to make your visits with us exceptional!

I have thoroughly read, completely understand, and agree to cooperate with and abide by the procedures outlined above.

I acknowledge that a copy of the "Office Privacy Policies" for MD Dental of Utah has been given to me.

Name of guest, parent/legal guardian (please print)

Date

Signature of guest, parent/legal guardian

MD Dental of Utah Witness

IMPORTANT DENTAL INSURANCE INFORMATION

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, limitations, deductibles and required co-payments and/or co-insurance.

OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing your insurance claim within 24 hours of your visit and requesting payment of your benefits to this office.
2. Assisting you in researching your dental insurance plan to determine available benefits.
3. Re-filing your insurance a second time within 45-60 days.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATION OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees not covered by your insurance plan is due at the time services are delivered/rendered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 65 days.
5. Keeping our office informed of any changes in your insurance coverage, home address, or employment.
6. Understanding that amounts and fees regarding treatment and insurance are an estimate and are subject to change.

Patient Name: _____ DOB: _____

Insurance Company: _____ Phone: _____

Insurance complete address: _____

Subscriber Name: _____ Employer: _____

Subscriber D.O.B.: _____ Subscriber SSN: _____ Ins. ID No. _____

Thank you for your cooperation with your dental insurance coverage. Please sign below and have your insurance card ready for us to make a copy to keep in your file.

I hereby authorize James D. Lund, DDS and/or all associates to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to MD Dental of Utah. I understand I am responsible for any unpaid balance, regardless of estimated quotes.

Signature of insured/subscriber, or legal guardian

Date