**Morris Dental Associates**

4709 Marlboro Drive

Abilene, TX 79606

(325) 692-1100

(325)692-2215

Patient Name (First, Last) Preferred Name

Address City Zip: State

Home Phone: Work Phone: Cell Phone:

Social Security Number Date of Birth Sex M/F

Marital Status: S M W D Email Address

Emergency Contact Name Relationship to Patient

Address Telephone number

**Parent/Legal Guardian (if patient is under 18)**

Parent/Guardian Name (First, Last) Preferred Name

Address City Zip: State

Home Phone: Work Phone: Cell Phone:

Social Security Number Date of Birth Sex M/F

Marital Status: S M W D Email Address(optional)

**Insurance Information (Please provide your insurance card to the receptionist)**

Policy Holders Name Relationship to patient

Policy holders Social Security Number Policy Holders D.O.B

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Examination, Treatment, and Financial Responsibility Agreement**

I hereby consent to and authorize the providers and employees to provide dental care to the patient identified below. If appropriate I authorize release of any dental information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide up to date insurance information prior to treatment. I also acknowledge that the filing of any insurance claim(s) is NOT A GUARANTEE OF PAYMENT and that I AM FINANCIALLY RESONSIBLE FOR PAYMENT if such claim(s) are partially paid, unpaid, or denied by the insurance company. I understand I am ultimately responsible for payment of services rendered. BALANCES LEFT UNPAID AFTER 90 DAYS WILL BE SENT TO COLLECTIONS. I am at least 18 years of age, or if not, I am accompanied by a legal guardian.

If patient is a minor, I hereby consent that the parent/legal guardian who brings in the minor child will be responsible for all copays and deductibles. I hereby affirm that I am the legal parent or guardian of patient and have authority to make decisions regarding dental treatment.

I authorize Morris Dental Associates to fax or email my records to any physician or pharmacy for the purpose of coordinating or managing my dental care. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the doctor, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

Signature of Patient or GuardianDate

Print Patient Name

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**OFFICE POLICIES AND RESPONSIBILITIES**

**As a courtesy to our Patients we will file on your insurance for you**

* When making an appointment with our office it is your responsibility to confirm with your insurance company that the provider is currently in network with your plan. We file on both in network and out of network plans.
* It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may contact the number on the back of your insurance card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies select certain services or diagnostic codes which they will not cover or downgrade to a lower coverage fee. Our office never guarantees that your insurance will pay. We will make every attempt to file your claim. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

**Deductibles and Co-Insurance**

* All claims are subject to a deductible if a procedure is performed. A deductible is the amount you are obligated to pay before your insurance company starts paying for your dental care. Co-Insurance is the percentage you are responsible for in addition to your deductible. Payment will be due at the time of service. You may be billed for these amounts should your insurance company notify us that additional payment is due from you.

**A valid Picture ID and your insurance card are required at the time of your office visit**

* Without a valid insurance card, we are unable to file a claim to your insurance company and you will be responsible for the day’s charges at the time of service
* It is your responsibility to notify the staff of any changes in your address, phone number, and/or insurance plan, and provide a current up to date insurance card at each visit. Failure to do so may cause your insurance claim to be rejected, thus making it your responsibility to pay the total cost of the visit.

**Missed Appointments, Late Cancellations, Late Arrivals, and Non-Compliance**

* We require a 24-hour advanced notice if you must cancel your appointment. For your convenience, we offer a reminder call and/or text 24-48 hours prior to your appointment which will allow you to cancel or reschedule at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.
* **If you miss an appointment without a 24-hour notice or cancel the same day as your appointment, a $50.00 cancellation fee will be added to your account and due at your next appointment.**
* Please let the office know if you have a fever blister, are running fever, or have any flu like symptoms so that we may reschedule your appointment.
* Our office follows the Abilene ISD bad/inclement weather schedule. If Abilene is running on a 2 hour late start, our first patient will be the scheduled 10 am patient. If your appointment was scheduled for an earlier time, we will call you when we get to the office to reschedule your appointment.
* We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past you scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.
* At times a procedure may take longer than anticipated or a patient has been worked in for an emergency which may cause our providers to run late. You won’t be rushed when you see the doctor if we are running behind.
* Patients with multiple cancellations or missed appointments must pay all fees before we will scheduling a following appointment and/or may be discharged from our practice.
* Please note that noncompliance with treatment plans and abusive/inappropriate behavior towards staff and or patients will result in immediate dismissal of your care from our practice.

**Forms of Payment**

* We accept payment in the form of cash, check, MasterCard, Visa, Discover, American Express, and Care Credit.
* Any checks returned to us due to insufficient funds will be charged the billed amount with a return fee of $30. Failure to do so within

**Collection Fees**

* Any Remaining balance after your insurance pays is your responsibility. All accounts not paid within 90 days will be sent to WCTCB collections agency.

**Minors**

* The parent(s) or guardian(s) of minor patients MUST accompany the child for the initial evaluation and sign an informed consent to treat your child. Future visits will be covered under this consent. It is the responsibility of the parent or guardian to provide current insurance information and payment in full for services provided, should the child be unaccompanied at future visits. Any child under the age of 15 must be accompanied by a parent/guardian for the duration of their appointment. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent’s responsibility to collect from the other parent.

I have read, and understand and agree to the above office and financial policies of Morris Dental Associates. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing by signing this statement. My signature below states my understanding of the Morris Dental Associates office and financial policies and also serves as a request and consent for treatment. I authorize and assign all benefits payments to be made directly to Morris Dental Associates.

Signature of Patient/Legal Representative Date

Name of Patient

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**HIPAA PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how Morris Dental Associates may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. The Notice is included in your new patient paperwork so that you may review it before signing this consent. As a patient you have the right to request restrictions on use and disclosure of your health information.

Disclosures of your health information or its use for any purpose other than those listed in our “Notice of Privacy Practices” and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure or information that occurred before you notified us of your decision.

**Persons Authorized to Receive Information About Your Care:**

I authorize Morris Dental Associates to release all information regarding my financial account, appointments, treatment and/or other information pertinent to my healthcare provided by Morris Dental Associates over the telephone, email, or in person to the following person(s) (i.e. spouse, family member, etc.):

|  |  |  |
| --- | --- | --- |
| Name Of Person | Relationship to Patient | Telephone Number |
|  |  |  |
|  |  |  |
|  |  |  |

I do not authorize any of the following information to be disclosed to any other parties except to me as the patient. (Please specify)

**Communication:**

I authorize Morris Dental Associates to leave messages in reference to any items that assist in carrying out healthcare operations including appointment reminders and billing issues.

Home phone: YES NO Cell Phone: YES NO Email: YES NO

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your dental insurance company. You have the right to revoke this consent in writing with your signature.

Signature of Patient/Legal Representative: Date:

Name of Patient:

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**PHOTO AND TESTIMONIAL RELEASE FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby grant permission to Dr. Amy Morris, DDS, to use my photograph and any testimonial I give regarding the dental care I receive from any such office, in any marketing, advertising or teaching materials used to market or advertise his/her dental practices, including use on Dr. Morris’s website or Facebook page. I acknowledge Dr. Morris’ right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that Dr. Morris may choose not to use my photograph and testimonial at this time, but may do so at her discretion at a later date. I also understand that once my image is posted on Dr. Morris’ website or Facebook, the image can be downloaded by any computer user, which is beyond the control of Dr. Morris, and I will hold him/her and any of her affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Parent/Guardian Signature

(If under age of 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Parent/Guardian Printed Name

(If under age of 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

To revoke this consent in writing, please contact

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**NEW PATIENT SURVEY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male Female Age: \_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were referred, who referred you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was said to you that interested you in trying out our office?

Friendly Insurance Provider Location Staff

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you responded to an advertisement, which one?

Billboard Facebook Internet TV

If you responded to an advertisement, what initially attracted your attention?

If you were to rate your smile on a scale from 1-10 (1 being the lowest and 10 the highest), how would you currently rate it?

1 2 3 4 5 6 7 8 9 10

If you have dental anxiety, on a scale from 1-10 (1 being the lowest and 10 the highest), how would you rate it?

1 2 3 4 5 6 7 8 9 10

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**TREATMENT TO MINORS**

Patient Name: Date of Birth

Many times parents/guardians find themselves unable to accompany their minor children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Morris Dental Associates permission to treat my child when they arrive at the office unaccompanied.

Signature of Parent/Legal Guardian Date