Enhance Dental Care of Lawrence

Patrick O. Moriarty, DDS. 3514 Clinton Pkwy, Ste G, Lawrence, KS 66047
785-832-2882

Consent to Examination

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.
Let my signature below evidence my consent to your dental examination. As a part of that examination, I understand that you and your staff may take x-rays, study models, photographs, and perform other diagnostic procedures which you deem appropriate to make a thorough diagnosis of my dental condition and needs.
I acknowledge to you that I have been given the opportunity to ask questions about the examination, the procedures to be used, and the risks involved-however slight. I believe that I have sufficient information to give you my consent.

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Insurance and Assignment of Benefits

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. Any questions regarding your benefit should be directed to your insurance company or human resource person at your place of employment. I understand that any claims that my insurance company has not paid within 45 days become my financial responsibility.
I authorize payment of insurance benefits directly to the doctor, otherwise payable to me. Any payment received by the doctor from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fee.

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Financial and Cancellation Policy

Payment is expected in full at the time of service, unless other arrangements have been made. I understand that I am subject to a service charge of 1.5% per month on any balances on my account over 90 days old. Payments are due within 15 days of billing date. Any payments received after 15 days will be assessed a $29 late fee.
A $35.00 charge will be billed to the patient's account for any check returned by the bank for any reason not paid. We will resubmit the check for payment to the bank. Delinquent accounts may be sent to a collection agency or referred for legal action. If your account is sent to a collection agency, the collection fees we incur will be added to your account. I have read and understand the cancellation policy and the financial policy of Dr. Moriarty and agree to all the terms described in it.
We reserve the right to charge a nominal fee of $58 for missed appointments or appointments cancelled with less than 48 hours or your appointment time.

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Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability (HIPAA) Act of 1996, I have certain privacy rights regarding my protected health information and uses for such information. I have received a copy of Enhance Dental Care of Lawrence office Notice of Privacy Practices, read and understand these practices. I understand that these practices may change at any time. I understand I may request in writing restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations. Enhance Dental Care of Lawrence may not agree to such requests, but if agreed to, then Enhance Dental Care of Lawrence is bound by said request.

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Signature____Date___________________