SoFlo Dental Studio
COSMETIC | IMPLANT | RESTORATIVE
1035 State Road 7, Suite 210 Wellington, FL 33414
561.792.8384 Off 561.792.8306 Fax
Carmine Scarfone, D.M.D. **Vincent S. Faso, D.D.S.**

Date: _____ Home Phone (____) _____

Email:_____ Cell Phone (____) _____
print clearly

PATIENT INFORMATION

Name_____ ***Social Security***#_____
Last First Middle Initial

Address_____ State_____ Zip_____
CITY

Sex M F Age_____ Birthdate_____ Married Widowed Single Minor

☐CASH ☐INSURANCE Copay: $_____ Est. Amount Owed: $_____ Separated Divorced

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer Phone_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified? _____Phone_____

Pharmacy Name & Address: _____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
if Patient - enter 'self' Last First Middle Initial

Relation to Patient_____ Birthdate_____ SS#_____

Address if different from Patient's_____Phone _____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Policy / ID # _____ Group #_____Driv. Lic. #_____

Name of other dependents under this plan_____

For Office Use Only:

This office charges a missed appointment fee of $25.00 - we appreciate a 48-hour courtesy call to cancel your appointment

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Financial Policy

This financial policy contains important information about billing and payment for our professional services. It outlines your responsibility as the patient and our responsibility concerning billing and payment for our services.

- Our practice participates with many health insurance companies. Our business office will submit the claim for any services rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our Dentists are participating in their insurance plan at time of service. **The burden of proof is the patient's responsibility and not the Dentist responsibility.**
- If patient is a member of an insurance plan with out-of- network benefits in which we do not participate, our office will also file the claim on the patient's behalf; however**, the patient is expected to make payment in full at time of service**.
- It is the patient responsibility to make payment at time of service for co-payment or deductible. Any services not covered by patient's insurance plan are the patient's responsibility and payment in full is expected at time of service.
- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral, the patient's visit may be rescheduled, or the patient may be personally responsible for payment for the services rendered by Our office.
- If you request the completion of medical forms or special letters from the Dentist, we may be charged at least $25.00 per form/letter for duplication.
- **Please, understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving the care they need. Therefore, our office may charge a fee of $25.00 for appointments not cancelled with 48 hours' notice.**
- Payment for professional services can be made by cash, credit card, debit card, or through special third-party financing with Care Credit (subject to credit approval).
- Major procedures may require a reservation fee up to $100 to secure a specialty appointment which may be non-refundable if appointment is canceled or changed without 48-hour notice. This reservation fee will be applied to your dental treatment received.
- **Insurance**: We are happy to bill both primary insurance out of courtesy for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portion do; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement.
- **Patient Payment**: The patient portion due for services rendered is expected at the time of service unless previous arrangements have been made. We except cash, checks and all major credit cards.
- **Financing**: We have financing options available through Care Credit. If you have an interest in this option, please consult with the office manager prior to the date of the schedule treatment.
- **No-shows/missed appointments**: We request notice to cancel or reschedule appointment of at least 48 hours (two business days) prior to the appointment as scheduled. If appropriate notice is not given, a charge of $25 per hour of scheduled appointment will be assessed of the patient's account (example: 1 hour or less appointment = $25 charge, 2 hr appointment = $50 charge, etc.)
- **Refunds for Unfinished Treatment**: If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or dentist.
- **Credits on an Account**: If insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- **Collections**: On occasion, after repeated attempts to collect the balance due, we may need to turn in account over to a collection agency. Should this occur, it was agreed the financially responsible party pays all finance charges, collection cost, attorney's fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

Signature of Patient/Guardian	Name of Patient/Guardian	Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures me may make of your protected health information. A copy of this Notice accompanies this Consent for you to take with you. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practice including any revision at any time by contacting us by phone or by mail at the above address.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand revocation of this Consent will not affect any action we took in reliance on the Consent prior to receipt of you revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

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 health care operations.

I have read, understand, and agree to the Financial Policy and Disclosure of Health Information. I understand a billing representative is available to me if I have any questions. I also acknowledge receipt of Dr. Scarfone D.M.D. & SoFlo Dental Studio Notice of Privacy Practices.

_____	_____	_____
Signature of Patient/Guardian	**Name of Patient/Guardian**	**Date**

AFTER THE EXAMINATION, A TREATMENT PLAN WILL BE EXPLAINED TO ME WHICH WILL ESTIMATE WHAT MY INSURANCE SHOULD PAY AND WHAT MY COPAYMENT WILL BE AT TIME OF TREATMENT, AND I AGREE TO PAY FOR ANY DENTAL SERVICES PROVIDED BY (Dr.Carmine Scarfone)ENTISTRY THAT MY INSURANCE COMPANY FAILS TO PAY.

_____ **Initial of Patient/Guardian**

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DENTAL TREATMENT CONSENT FORM

Please read and initial items checked below
And read and sign the section at the bottom of form. Patient Name _____

❑ **1. DIAGNOSTIC AND PREVENTIVE**
I understand that I am having the following work done: Xrays_____Cleaning_____ Scaling_____Other_____
(Initials_____)

❑ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

❑ **3. NITROUS OXIDE**
I understand that nitrous oxide (laughing gas) provides relaxation to make it more comfortable for me to receive the necessary dental care with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history. (Initials_____)

❑ **4. LOCAL ANESTHETIC**
I understand there are risks of local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in my medical history. (Initials_____)

❑ **5. REMOVAL OF TEETH**
Alternatives to removal have been explained to me and I authorize the dentist to remove the following teeth _____. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_____)

❑ **6. CROWNS AND BRIDGES**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge will be before cementation. (Initials_____)

❑ **7. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (Initials_____)

❑ **8. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

❑ **9. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.**

Signature of patient or legal guardian _____ Date_____