Michael W. Richard, DDS, PA
2702 Campus Dr.
Garden City, KS 67846

PATIENT INFORMATION

Date_____

( ) Married ( ) Single ( ) Divorced ( ) Widowed ( ) Minor ( ) Male ( ) Female

Name_____
First Middle Last Preferred Name

Address_____
Street Apt # City State Zip

Birthdate_____Employer_____ Occupation_____
Mo Day Year

SS#_____Email_____

Telephone_____
Home Work Cell Other

RESPONSIBLE PARTY (If someone other than the patient) or SPOUSAL INFORMATION

Name_____
( ) Married ( ) Single ( ) Divorced ( ) Minor ( ) Male ( ) Female
First MI Last

Address_____
Street Apt # City State Zip

Birthdate_____Telephone_____
Mo Day Year Home Work Cell Other

Place of Employment_____SS#_____Email_____

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Last First MI	Last First MI
Street City State Zip	Street City State Zip
Home # Work # Cell	Home # Work # Cell
( ) Self ( ) Spouse ( ) Child ( ) Other	( ) Self ( ) Spouse ( ) Child ( ) Other
Date of Birth (Mo/Day/Yr) Relationship to Patient	Date of Birth (Mo/Day/Yr) Relationship to Patient
Employer Name of Dental Insurance	Employer Name of Dental Insurance
SS# Member ID # Group#	SS# Member ID # Group#
_____ Insurance Co Address Insurance Co Telephone	_____ Insurance Co Address Insurance Co Telephone

Has any member of your family ever been treated in our office? ( ) Yes ( ) No

Whom may we thank for referring you to our office?_____

AUTHORIZATION

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I understand that I am responsible for all costs of dental treatment regardless of insurance or any other third party involvement.

Date Patient or Responsible Party Signature State Driver's License #

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INFORMACION DePACIENTE

Fecha_____

( ) Casado ( ) Soltero ( ) Divorciado ( ) Menor ( ) Masculino ( ) Femenino

Nombre_____
Primer Middle Apellido Apodo

Direccion_____
Calle Apt # Ciudad Estado Codigo Postal

FecheNacimiento_____Empleador_____Ocupacion_____
Mes Dia Ano

Seguro Social _____Correo Electronico_____

Telefono_____
Casa # Trabajo # Celular # Otro

PERSONA RESPONSABLE (alguien mas que no es el paciente)

Nombre_____ ( ) Casado ( ) Soltero ( ) Divorciado ( ) Menor ( ) Masculino ( ) Femenino
Primer Middle Apellido

Direccion_____
Calle Apt # Ciudad Estado Codigo Postal

FecheNacimiento_____Telefono_____
Mes Dia Ano Casa Trabajo Celular Otro

Lugar de Empleo_____Seguro Social_____Correo Electronico_____

INFORMACION de ASEGURANZA

ASEGURANZA PRIMARIA	ASEGURANZA SEGUNDA
Apellido Primer MI	Appellido Primer MI
Calle Ciudad Estado Codigo Postal	Calle Ciudad Estado Codigo Postal
#Casa # Trabajo # Celular	# Casa # Trabajo # Celular
( ) Paciente ( ) Esposalo ( ) Hijola ( ) Otro	( ) Paciente ( ) Esposalo ( ) Hijola ( ) Otro
Feche de Nacimiento (Mas/Dia/Ano) Relacion al Paciente	Feche de Nacimiento (Mas/Dia/Ano) Relacion al Paciente
Empleador Nombre de Aseguranza	Empleador Nombre de Aseguranza
#Seguro Social # ID de Miembro # Numero de Grupo	# Seguro Social # ID de Miembro # Numero de Grupo
_____	_____
Direcion de Aseguranza Numero de Telefono de Aseguranza	Direcion de Aseguranza Numero de Telefono de Aseguranza

Alguin miembro de su familia a tenido tratamiento en nuestra oficina? ( ) Si ( ) No

A quien le agradecemos por referirlo a nuestra oficina?_____

AUTORIZACION

Yo porla presente autorizo a la oficina dental que administre tal medicamentos y que realize diagnosticos, fotografias y procedimientos terapeuticos que sean necesarios para tratamiento dental adecuado. Yo entiendo que yo soy responsable por todos los costos del tratamiento dental si la aseguranza o otra tercer persona.

Fecha Firma de Paciente o persona responsable # de Licensia

Michael W. Richard, DDS, PA
PAYMENT POLICIES

Thank you for selecting us as your dental health care provider. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. If you have any questions or concerns about our financial policies, please do not hesitate to ask one of our business coordinators.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience Mastercard, Discover, Visa and CareCredit.

Prepayment Discount

We offer a 5% **prepaid** discount on cases over $500.00 when:

1. Patient has no dental insurance.
2. Patient has no dental insurance coverage for specified procedures.
3. Patient chooses to accept assignment of benefits and pays our office directly.

Payment must be made in advance of treatment provided.

Insurance

We will accept assignment of insurance benefits. If we are a participating provider for your insurance company, your estimated deductible and co-insurance amounts are due at the time of treatment. **Any balance due after your insurance company has paid their portion or denied payment is your responsibility**. Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance company unless you give us current and correct information, which includes a copy of the current insurance identification card, social security #, full and legal name, birth date of the insured, and current address. Please be aware that some of the services may be non-covered services.

Our office is an "in-network" preferred provider for Blue Cross Blue Shield of Kansas and for Delta Dental of Kansas.

We do not accept Medicaid or Medicare.

Service Charges

Please be advised that if your account is not paid in full at 90 days, there will be a $15.00 monthly billing charge or a finance charge of 1.5% per month (annual periodic rate of 18%), whichever is greater. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees. There will be a $30.00 service charge for insufficient checks.

Authorization

I hereby authorize this office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I understand that I am responsible for all costs of dental treatment regardless of insurance or any third party involvement.

State Driver's License #_____ Signature_____

HIPAA ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient:_____

I give my permission to release Any and/or All Information to the following individuals:

*
*
*

Signature: *_____