Darrell A. Meeks, D.M.D., LTD
Oral and Maxillofacial Surgery

Dear Patient,

We would like to welcome you to our Oral & Maxillofacial Surgery practice. Our office is committed to deliver your treatment in the most efficient and comfortable manner possible. We encourage your active participation by freely discussing the diagnosis, treatment, and any other questions that you may have.

Some of the most frequent questions we are asked are related to fees and billing procedures. We require fees for consultation, diagnostic, and surgical services to be paid when services are rendered. Our office staff can assist you with an estimate of your charges prior to treatment.

If you have any insurance that covers our services, we will collect your estimated copay the day of surgery. We will file your insurance as a courtesy for you, also assisting with pre-authorization to determine estimated insurance benefits prior to treatment. Please keep in mind that insurance is a method of reimbursement, not a substitute for payment. The responsibility of payment remains with you.

Attached you will find our financial policy as well as medical history, patient information, and HIPAA form.. **Please be sure to fill out all paperwork (front and back) in its entirety.** You will be escorted to one of our consultation rooms for a consultation, laboratory studies as needed and or x rays to be taken (if we have not received current x-rays from your general dentist.) once you have completed these forms. We will need to make a copy of medication lists, insurance card(s), and a photo ID.

In addition, we understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A **$50.00** charge will be assessed for multiple missed, short notice or canceled appointments **without 24 hour notification**. Multiple failed appointments may result in being dismissed from the dental practice. General anesthesia appointments will be charged a **$150.00 broken appointment fee**.

You can be assured that we will do everything in our power to make your visit with us as pleasant as possible.

Dr. Darrell A. Meeks & Staff

Initials: _____ Name:_____ Date_____

Patient Treatment and Financial Policy

Thank you for choosing our office as your Oral and Maxillofacial Surgeon.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, certified bank checks, money orders, MasterCard, Visa, Discover, American Express and CareCredit.
Outside financing is available upon request and approval.
Please Note: Additional fee of **$50.00** will be applied for returned checks. All account balances over 30 days are subject to a late fee.

Do you have Insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you;however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility. Please contact your insurance company for details of our benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefits may differ due to a number of reasons, specifically related to your plan.

Initials [ ]

- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. **Initials [ ]**

- We require that you pay the deductible, co-payment, and co insurance, which is the estimated amount not covered by your insurance company by cash, money order, MasterCard,Visa, American Express, Discover, or CareCredit, at the time we provide the service to you.

- Insurance payments are generally received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian; The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at the time of services. Unaccompanied Minors: Minors must be accompanied by parent, legal guardian, or caregiver with written and signed permission from a parent or legal guardian.

I accept responsibility for payment of all charges incurred as well as attorneys' fees and any other related costs of collections should such action become necessary. **Initials [ ]**

Consent: I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment(s).
In addition, I hereby acknowledge that a copy of this office's Notice of Privacy Practices (HIPAA) has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Patient Name (Printed)_____

Patient/Parent (Signature) _____ Date _____

MEDICAL HISTORY

Patient Name_____ Phone#_____

PHARMACY NAME _____Phar. phone #:_____Pharmacy Address_____

Sedation purposes: Height_____Weight_____ Primary Dentist Name:_____

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an interrelationship with the medical help you will receive. Thank you for answering the following questions.

Have you ever had any serious illness, so please list._____

-Primary Care Physician Name: _____ Phone Number: (_____)_____-_____

-Have you recently been hospitalized or had a major operation? Yes / No

-Have you ever had a head or neck injury? Yes / No

-Do you take, or have taken, Bisphosphonates (Fosamax/Boniva/Reclast/Zometa/Actonel)? Yes / No

-Do you take, or have taken, Blood Thinners (Coumadin/Lovenox/Pradaxa/Eliquis/Xarelto/Plavix)? Yes / No

If yes, please fill Prescriber's Info: _____

-Do you take, or have taken, Barbiturates or Sleeping Pills? Yes / No

-Do you use tobacco? Yes / No

-Do you use Cannabis? Yes/ No

-Do you use Kratom? Yes/ No

Females: Pregnant/trying to get pregnant? YES/NO Taking oral contraceptives? YES/NO Breastfeeding? YES/NO

Are you allergic to any of the following?

Aspirin \ Penicillin or other Antibiotics \ Codeine or other Narcotics \ Local Anesthetics \ Acrylic \ Metal \ Latex \ Sulfa Drugs \ Other allergies? _____ NO known allergies

Do you have, or have you had, any of the following? Please check all that apply:

☐ **AIDS/HIV**	☐ **Diabetes Type 1**	☐ **Hepatitis A**	☐ **Psychiatric Care**
☐ **Alzheimer's Disease**	☐ **Diabetes Type 2**	☐ **Hepatitis B/C**	☐ **Radiation Treatments**
☐ **Anemia**	☐ **Drug Addiction**	☐ **Herpes**	☐ **Recent Weight Loss**
☐ **Angina**	☐ **Easily Winded**	☐ **High Blood Pressure**	☐ **Renal Dialysis**
☐ **Anxiety**	☐ **Emphysema**	☐ **High Cholesterol**	☐ **Rheumatic Fever**
☐ **Anemia**	☐ **Epilepsy/Seizures**	☐ **Hives/Rash**	☐ **Rheumatism**
☐ **Arthritis/Gout**	☐ **Excessive Bleeding**	☐ **Hypoglycemia**	☐ **Scarlet Fever**
☐ **Artificial Heart Valve**	☐ **Excessive Thirst**	☐ **Irregular Heartbeat**	☐ **Shingles**
☐ **Artificial Joint**	☐ **Fainting/Dizziness**	☐ **Jaundice**	☐ **Sickle Cell Disease**
☐ **Asthma**	☐ **Frequent Cough**	☐ **Kidney Problems**	☐ **Sinus Trouble**
☐ **Blood Disease**	☐ **Frequent Headaches**	☐ **Leukemia**	☐ **Sleep Apnea**
☐ **Blood Transfusion**	☐ **Genital Herpes**	☐ **Liver Disease**	☐ **Stomach/Intestinal Disease**
☐ **Breathing Problem**	☐ **Glaucoma**	☐ **Low Blood Pressure**	☐ **Stroke**
☐ **Bruise Easily**	☐ **Hay Fever**	☐ **Lung Disease**	☐ **Swelling of Limbs**
☐ **Cancer**	☐ **Heart Attack/Failure**	☐ **Lyme Disease**	☐ **Thyroid Disease**
☐ **Chemotherapy**	☐ **Heart Murmur**	☐ **Mitral Valve Prolapses**	☐ **Tonsillitis**
☐ **Cold Sores/Fever Blister**	☐ **Heart Pacemaker**	☐ **Osteoporosis**	☐ **Tuberculosis**
☐ **Congenital Heart Disorder**	☐ **Heart Trouble/Disease**	☐ **Pain in Jaw Joints**	☐ **Tumors/Growth**
☐ **Convulsions**	☐ **Hemophilia**	☐ **Parathyroid Disease**	☐ **Ulcers**
☐ **Cortisone Medications**		☐ **POTS**	☐ **Venereal Disease**

Please <u>SIGN</u> and list all medications currently taking on <u>BACK OF PAGE:</u>

*****To the best of my knowledge the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.*****

Patient (Guardian) Signature:_____ Date:_____

Current Medications

WELCOME TO DR. DARRELL A. MEEKS D.M.D PRACTICE

PATIENT'S NAME:_____MI_____**Phone#**_____ **BIRTHDATE**_____

SS#_____ MALE / FEMALE EMAIL_____

ADDRESS_____ CITY_____STATE_____ ZIP_____

GENERAL DENTIST _____ DENTIST #_____

EMPLOYER_____ BUSINESS #_____

EMERGENCY CONTACT_____ #_____ RELATIONSHIP_____

****RESPONSIBLE PARTY FOR ACCOUNT** : SELF / SPOUSE / FATHER / MOTHER / OTHER _____

****RESPONSIBLE PARTY NAME**_____

*****RESPONSIBLE PARTY SOCIAL SECURITY # _____ & BIRTH DATE**_____

DENTAL INSURANCE SUBSCRIBERS NAME_____ID #_____

PRIMARY INSURANCE _____ P.O.BOX # _____ STATE_____

Id #_____ GROUP #_____ EFFECTIVE DATE_____

SECONDARY INSURANCE _____P.O.BOX_____ STATE_____

Id#_____ GROUP # _____ EFFECTIVE DATE_____

HEALTH INSURANCE SUBSCRIBER NAME_____ ID #_____

PRIMARY INSURANCE _____ P.O.BOX # _____ STATE_____

Id #_____ GROUP #_____ EFFECTIVE DATE_____

SECONDARY INSURANCE _____P.O.BOX_____ STATE_____

Id#_____ GROUP # _____ EFFECTIVE DATE_____

Patient Consent to receive Mail, Email and Telephone messages

_____

LAST NAME FIRST NAME MIDDLE INITIAL

I AGREE THAT THE PRACTICE MAY COMMUNICATE WITH ME ELECTRONICALLY AT THE FOLLOWING ADDRESS:

EMAIL :_____

PLEASE PROVIDE US WITH THE BEST PHONE NUMBER(S) TO REACH YOU

_____ _____ _____

CELL / HOME WORK OTHER

DO WE HAVE YOUR PERMISSION TO :

– SEND AN APPOINTMENT REMINDER POSTCARD TO YOUR HOME? YES/NO

-LEAVE A VOICEMAIL OR SEND EMAILS IN REGARDS TO YOUR ACCOUNT? YES/NO

_LEAVE A VOICEMAIL WITH YOUR APPOINTMENT INFORMATION? YES/NO

I GIVE PERMISSION TO SHARE APPOINTMENT, BILLING OR DENTAL INFORMATION WITH THE PERSON NAMED BELOW:

_____ _____

NAME RELATIONSHIP

_____

SIGNATURE OF PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF **THE NOTICE OF PRIVACY PRACTICES** DISPLAYED FOR YOU ON OUR OFFICE WALL. **(COPY UPON REQUEST)**

I, _____ HAVE RECEIVED A COPY AND OR READ THE PRIVACY PRACTICES DISPLAYED IN OUR OFFICE AS WRITTEN ABOVE.

SIGNATURE _____.

DARRELL A MEEKS, D.M.D, LTD.
ORAL AND MAXILLOFACIAL SURGERY

24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

24 HOUR CANCELLATION & "NO SHOW" FEE POLICY recognizes that everyone's time is valuable and the appointment time is limited. We ask that you provide a **24 hour notice** if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Therefore, Dr. Meeks Oral and Maxillofacial Surgery reserves the right to charge a fee of **$50.00** for each missed, "NO SHOW" appointment or is not canceled within a 24 hour advance notice. Sedation appointments that are a "NO SHOW" or are canceled less than 48 hours in advance will be charged a **$150.00 fee**. NO SHOW fees will be billed to the patient. This fee is not covered by insurances, and must be paid prior to your next appointment.
3 "NO SHOWS" in any 12 month period will result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

PRINT FULL NAME **DATE**

_____

SIGNATURE