HERSHEY DENTAL ASSOCIATES, L.L.C.

Financial Policy

We would like to thank you for choosing us as your dental provider. We are committed to providing you with comprehensive and quality dental care, and your clear understanding of our financial policy is very important to our professional relationship. Please understand that the payment of your bill is considered a part of your treatment. Following is a statement of our Financial Policy which we require that you read and sign prior to treatment. All patients must also complete a Patient Information/Health History and an Acknowledgement of Receipt of Notice of Privacy Practices before being seen by the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS COVERED BY PARTICIPATING INSURANCE CARRIER. WE WILL GLADLY ACCEPT MASTERCARD, VISA, DISCOVER, DEBIT CARDS, CASH OR PERSONAL CHECK. WE ALSO OFFER CARE CREDIT FOR TREATMENT PLANS OVER $500.00.

Regarding Insurance: **All charges you incur at each dental visit 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, your employer, and the insurance company. It is ultimately the patient's responsibility to know details of your dental benefits. It is also the patient's responsibility to verify if the practice is in or out of network with his or her insurance policy and to be aware of your maximum allowance. As a courtesy, it is our staff's only responsibility to assist patients in filing out and submitting the insurance claim. Patients with dental insurance will be responsible to pay the estimated insurance copayment of a procedural allowance and deductible at the beginning of treatment. As well as, authorize the assignment of the insurance benefits to us. After insurance benefits are received, if there is an overpayment, a refund will be sent to you. **If there is an additional amount due, we will send a statement balance. If it is a non participating insurance, any charges incurred in our office are your responsibility at time of service**; we will still file your insurance claim, and will mark the payment as payable to you directly. Your insurance claim can **ONLY** be submitted if we are supplied with the proper insurance information from you (i.e.: **insurance company address and phone number, subscriber's identification number and group number**). It is your responsibility to make sure your policy is active on your date of service. If your insurance company has not paid your claim within 45 days please contact your insurance company. Your dental plan may not cover certain procedures; however this does not mean these treatments are unnecessary. If you have questions regarding your dental plan, or a problem with a reimbursement level, contact your employer or insurance company. Our staff may be able to explain dental plan issues to you. But, it is your responsibility to be educated on the levels of coverage provided by your plan. **Patient's Initials: _____**

Usual and Customary Rates: Our practice is committed to providing good 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 what is an appropriate charge.

Missed appointments: Unless appointments are cancelled at least 24 hrs in advance, our policy is to charge $30 for missed appointments. Please help us to serve you better by keeping scheduled appointments.

Returned Checks: Patients will be charged $50 for each returned check, and are responsible for the amount owed.

Accounts: After 60 days from the date of service a 35% collection fee will be added to your account if there has been no attempt to make payment or set up a payment schedule. All accounts delinquent over 90 days and without a payment schedule will be turned over to a collection agency for further collection procedures. All past due accounts must be paid in full before you can scheduled another appointment.

I have read and understand the financial policy as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date

HERSHEY DENTAL ASSOCIATES, L.L.C.

Information about Dental Insurance

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurances; we realize how confusing it can be. To begin, we would like to highlight a misconception- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid by you or your employer. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient. Ultimately financial responsibility falls on the patient.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask the front desk staff, insurance coordinator, and/or office manager for clarification on services, billing, and insurance.

Sincerely,

Hershey Dental Associates, LLC

Patient Name: _____

Patient Signature: _____ Date: _____

Staff Responsible: _____ Date: _____

ACQUAINTANCE FORM

It is important that we get to know about you including your dental and medical history. many things have a direct bearing on our dental health. We will review this questionnaire and discuss it with you in detail. the information you give us is strictly confidential and will not be released to anyone without your permission.

PATIENT INFORMATION

Patient's Name_____Email address_____

Address_____

Telephone: Home_____Cell_____Social Security #_____Date of Birth_____

Employer Name_____Work Telephone_____

Marital Status_____If Married, Spouse's Name_____

How Did you Happen To Chose Our Office? (Please circle) Magazine Google Location Personal Referal:_____

EMERGENCY INFORMATION

In Case of Emergency Contact_____ Relationship _____

Address_____Telephone_____

RESPONSIBLE PARTY INFORMATION

Person Responsible For Payment_____Relationshp_____

Address_____

Telephone_____Social Security #_____Date of Birth_____

INSURANCE INFORMATION

Dental Insurance Company Name_____

Address_____

Group #_____Subscriber Name_____Social Security #_____

IF DUAL COVERAGE--THE SECONDARY INSURANCE COMPANY:

Insurance Company Name_____Employer_____

Address_____Group #/Policy #_____

Relationship_____Subscriber Name_____Social Security #_____

MEDICAL HISTORY

*Please check or circle any of the following which you **have** or **have had** and explain where necessary. List pharmaceuticals (**prescribed medication**s) you are taking now for this problem.*

☐1 . AIDs_____

☐2. Anemias or Blood Discrasias_____

☐3. Arthritis, Rheumatoid or Osteo_____ _____

☐4. Asthma_____

☐5. Autoimmune Problems_____

☐6. Birth Control Pills, Hormone Replacement Therapy or Fertility Problems_____

☐7. Blood Clots or Stroke: Y/N Treatment: _____

☐8. Bone Problems, Osteoporosis
Treatment w/Bisphosphonates(Please circle or write): Fosamax Actonel Boniva Zometa oral or injection
Other:_____

☐9. Cancer or Tumors: Y/N Current Treatment:_____ Previous Treatment:_____

☐10. Depression or Nervous Disorders_____

□11. Diabetes: Type I or Type II

□A. Oral Medication_____ □B. Insulin Injections_____

□12. Digestion Problems, Acid Relux, GERD_____

□13. Epilepsy or Seizures: Y/N Last episode:_____

□14.Hayfever or Allergies other than medications_____

□15.Heart Problems_____

□A. Cardiac Bypass Surgery_____□B. Cardiac Pacemaker_____

□C. Congenital Heart Defect_____ □D. Prosthetic Heart Valve_____

□E. Heart Attack_____□F. Heart Murmur, Mitral Valve Prolaspe_____

□16. Hepatitis A,B, C or Liver Disease_____

□17.High Blood Pressure_____ □18. Low Blood Pressure_____

□19. Joint Replacement_____ Premedication: Y/N Antibiotic:_____

□20. Kidney Problems_____

□21. Lung Disease, COPD_____

□22. Muscle diseases_____

□23. Social Diseases_____

□24. Thyroid Diseases_____

□25. Tuberculosis or Symptoms of Tuberculosis_____

□26. Other diseases not listed_____

Please list any vitamins, supplements or herbal/homeopathic remedies that you are currently taking:

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following:

□ Antibiotics □1.Penicillin □2.Erythromycin □3.Tetracycline □4.Sulfa □5.Keflex □6.Clindamycin □7.Other_____

□Local Anesthetics like Lidocaine or Septocaine or Carbocaine □Epinephrine sensitivity_____

□Aspirin □Codeine □Ibuprofen, Motrin, Advil □Aleve □ Narcotics_____

□Latex □Metals of any kind_____

□Other allergies to materials or medications_____

Have you ever been advised to take medication (antibiotics or other medications) before a dental appointment? Y/N (circle)
If so, please explain_____

Have you ever had a skin rash or a reaction to metal jewelry? Y/N (circle) To What?_____

Do you wear contact lens? Y/N (circle) Do you bleed excessively upon injury? Y/N (circle)

Do you drink alcohol? Y/N (circle) _____daily _____weekly _____monthly _____ socially_____

Do you smoke now or **have you ever** smoked? Y/N (if yes number of years) cigarettes/day_____

cigars_____ pipes_____ chewing tobacco or snuff_____

Women: Is there a possibility that you may be pregnant or trying to get pregnant? Y/N (circle)

If yes, how many months pregnant? _____

Are you in a job that regularly exposes you to radiation or chemicals? Y/N (circle) _____

Have you ever had counseling for addictions to alcohol and/or prescription medications? Y/N (circle)

_____

Do you have reason to believe you are at risk for contacting infectious or sexually transmitted diseases?

Y/N (circle) If yes, please explain_____

Have you been a patient in the hospital in the past two years Y/N (circle) If so, please explain_____

_____

Date of last medical visit for a checkup or physical_____

Physicians name, address and phone number:_____

Are you experiencing emotional or physical stress or pressure in your work or at home? Y/N (circle)

Please explain_____

Is there anything other in your medical history that we have missed? _____

DENTAL HISTORY

How long has it been since you were to see a dentist?_____

What service was rendered?_____ Were x-rays taken? Y/N (circle)_____

When was the last time a full series of x-rays was taken of your teeth?_____

Have you had regular cleanings and exams? Y/N (circle)

Do you have a fear or phobia or the dentist that prevents you from visiting the dentist on a regular basis? Y/N (circle)
Would you be interested in help to deal with this fear, such as the use of Nitrous Oxide? Y/N (circle)

Have you lost teeth? Y/N (circle) Why?_____

Have you had complications with extractions?_____

Have you worn braces?_____ When?_____ How Long?_____ Do you still wear retainers?_____

Have you had treatment for periodontal disease (gum disease) or where you told you had periodontal disease?_____ Please explain and give dates_____

How often do you brush your teeth? ____x/day AM___PM___ Do you floss?_____x/day

Do you use other hygiene aids?_____

Do your gums bleed when you brush?____ or floss?_____

Do you have an unpleasant taste in your mouth?_____

Are there any areas of your mouth where foods collects or wedges between your teeth?_____

Have you noticed a dry mouth? Y/N Excessive water drinking/sipping? Y/N Frequent Use of Lozengers? Y/N

Do you have clicking or popping sounds when you open or close your mouth?_____ Pain?_____

Do you clench or grind your teeth either during the day or at night?_____

Do you experience headaches?_____ Frequency? _____When do they come?_____

Are any of your teeth sensitive?_____ Sweets? _____Cold?_____ Hot?_____ Pressure?_____

Are you interested in mercury safe removal of amalgam (mercury) fillings?_____

TREATMENT AUTHORIZATION

I consent to whatever dental procedures and anesthetics are necessary for treatment. I also understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of Patient or Guardian_____Date_____

Signature of Dentist_____Date_____

HERSHEY DENTAL ASSOCIATES, L.L.C.

Photo and Testimonial Release Form

I, _____, hereby grant permission to Hershey Dental Associates, LLC to use my photograph and any testimonial I give regarding the dental care I receive from any such office, in any marketing, contests, advertising or teaching materials used to market or advertise his/her dental practices, including use on Hershey Dental Associates, LLC's website. Hershey Dental Associates, LLC will not utilize your likeness or image without your expressed and written permission.

I acknowledge Hershey Dental Associates, LLC may choose not to use my photograph and testimonial at this time, but may do so at Hershey Dental's own discretion at a later date.

I also understand that once my image is posted on Hershey Dental Associates, LLC's website, the image can be downloaded by any computer user, which beyond the control of Hershey Dental Associates, LLC, and I will hold the practice and any of its affiliates 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: _____ Date:_____

(Parent/Guardian signature if under age of 18)

To revoke this consent in writing, please contact:
Hershey Dental Associates, LLC
273 Hershey Road
Hummelstown, PA 17037