FINANCIAL RESPONSIBILITY

Thank you for choosing Burlison Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

Cash, Check, Visa, Mastercard, American Express and Discover

Monthly Financing Options Available:

* NO INTEREST Payment Plans from CareCredit Allow you to pay over time, 6-12 months, with NO interest (subject to credit approval). No annual fees or pre-payment penalties

For Patients with Dental Insurance:

For patients with dental insurance: we are happy to work with your primary dental insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment. You are responsible for your estimated payment at time of service.

Some insurance companies pay the patient directly, not us. This is a function of each specific plan your employer has chosen for you. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Please remember you are fully responsible for all charges by this office regardless of your insurance coverage. We will file ONE appeal on your behalf. If your insurance carrier has not paid the claim within 60 days, your are responsible for the entire balance and finance charges of 18% APR will incur. A $25 late fee may be assessed on your account if the amount due is not paid by the due date. Burlison Dentistry charges $65 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature:_____ Date:_____

Patient Name (Please Print)_____

FACTS YOU SHOULD KNOW ABOUT INSURANCE

Thank you for choosing Burlison Dentistry. We strongly feel our patients deserve the best possible care and we would like to share some facts about dental insurance with you.

Fact 1: Dental insurance is NOT meant to be a PAY-ALL, its only meant to aid.

Fact 2: Many plans tell their insured that they will be covered “up to 80%-100%.” Despite what you are told, we have found that most plans cover 40%-70% of an average fee. The amount that your plan pays is determined by THEIR fee schedule and those benefits are largely based on how much your employer paid for the plan. Remember, you get back only what the employer puts in, less the profits of the insurance company. Most insurance plans have a maximum benefit and a deductible each year that has not changed since the 1970’s.

Fact 3: It has been the experience of many dentists that some insurances tell their customers the “fees are above the usual and customary fee” when a much more accurate statement would be, “Any difference in the fee charged, and the benefits payed, is due to limitations in the plan contract.”

Fact 4: Some dental services are not covered by insurance carriers. Please do not hesitate to ask us any questions about our policies. We want you to be comfortable in dealing with these matters, and we urge you to consult with us if you have any questions regarding our services and/or fees. We will gladly file with your insurance company and will make every effort to maximize your insurance benefits

However, please remember that ultimately, you are financially responsible for your account with our office, not your insurance company.

I authorize payment of dental treatment directly to Burlison Dentistry for all dental services

I authorize release of any dental information necessary to process insurance claims

_____ _____

signature date

BROKEN APPOINTMENT POLICY

We work hard to meet and accommodate the needs of all our patients and we are dedicated to providing you with the best dentistry and services available

Time is specifically reserved for you on our schedule. Therefore, when a sufficient notice is not given to cancel or change an appointment, it does not give enough time to contact another patient on our waiting list who would benefit from coming in earlier.

If you need to cancel or change and appointment, 48 hours notice (business hours) is required to prevent a broken appointment fee of $100 from being applied to your account and due immediately.

The second subsequent cancellation fee will be in the amount of the appointment scheduled, a third subsequent cancellation will result in the dismissal from the practice.

For your convenience, we do have an answering machine available if you need to call after hours to cancel an appointment

I,_____, understand and agree with the above office policies.
please **print** patient name

_____ _____

Patient signature date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____

E-mail:_____

Patient #:_____

Social Security #:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. 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. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: 678-473-4756 **Fax:** 678-473-7691 **Email**: Burlisondmdoffice@gmail.com

Address: 4055 B Johns Creek Parkway Suwanee, GA 30024

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 that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to 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.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

MEDICAL INFORMATION RELEASE FORM

Name:_____
Date of Birth:_____

Release Information

[ ] I hereby authorize Burlison Dentistry and Dr. Shelton Keith Burlison to release my protected health information, including the diagnosis, records; examination rendered to me, scheduled appointments, account and claims information. This information may be released to

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing

MESSAGES

Please call: [ ] my home_____ [ ] my work_____

[ ] my cell_____

Record Transfer

In the event a record transfer is requested, please send my electronic records to my email address _____

Signed_____ **Date**_____

Patient health record

Name: (Mr. Mrs. Miss Dr.)_____ Date:_____

Age:_____ Date of Birth:_____ SS#_____

Home Address:_____ City:_____ Zip:_____

Email Address:_____

Home Phone:_____ Cell:_____ Work Phone:_____

Spouse Name:_____ Cell:_____ Work Phone:_____

Minor Children's Names/Ages _____ Will they be patients?_____

Employer:_____ Occupation:_____ Spouse Occupation:_____

Emergency Contact name:_____ Number:_____

Insurance Co:_____ Policy#:_____ GP#:_____

Insurance ID #:_____ Insured Date of birth:_____

Address for Insurance Submission:_____

Spouse Employer:_____ Spouse Ins. Co:_____

Who is the Insurance Subscriber?_____

Pharmacy:_____ Phone:_____

Name of Last dentist:_____ Phone:_____

Why did you leave last dentist?_____

Medical Health

Date of last physical exam:_____

Primary Physician Name: _____ Phone:_____

Have you been hospitalized or under a physician's care in the past 2 years? ⬜ Yes ⬜ No

for:_____

Any major surgeries? ⬜Yes ⬜No Please describe:_____

Knee or Hip replacement? ⬜Yes ⬜No Date:_____

Do you take antibiotics prior to dental work? ⬜Yes ⬜No

Are you pregnant or nursing? ⬜Yes ⬜No Do you take birth control pills? ⬜Yes ⬜No

Do you take osteoporosis meds, Fosamax, Bonvia or other bisphosphonates? ⬜Yes ⬜No

Allergic to: ⬜ Latex ⬜Local Anesthetics ⬜ Penicillin ⬜ Aspirin ⬜NSAIDS ⬜Codeine

⬜ Food:_____ Other:_____

Please list **ALL** medications and supplements:_____

_____

_____

Have you had or now have:

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Emphysema/COPD	☐	☐	Radiation Therapy
☐	☐	Atrial Fibrillation	☐	☐	Epilepsy/Seizures	☐	☐	Respiratory problems
☐	☐	ADD/ADHD	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	AIDS/HIV Positive	☐	☐	Gastric Reflux	☐	☐	STD
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Severe Gag Reflex
☐	☐	Anemia	☐	☐	Hepatitis	☐	☐	Sickle Cell Anemia
☐	☐	Angina?Chest pain	☐	☐	Herpes/Fever Blister	☐	☐	Sleep Apnea
☐	☐	Artificial Heart Valves	☐	☐	Kidney Disease	☐	☐	Smoke/Dip
☐	☐	Artificial Joints	☐	☐	Liver DIsease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Organ Transplant	☐	☐	Thyroid Disease
☐	☐	Cancer	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Pacemaker	☐	☐	Ulcers Stomach
☐	☐	Compromised Immunity	☐	☐	Pneumonia			
☐	☐	Congenital Heart Defects	☐	☐	Prolonged Bleeding			Anything Not Listed:_____
☐	☐	Diabetes	☐	☐	Prolonged cough			
☐	☐	Diarrhea	☐	☐	Psychiatric Care			
☐	☐	Drug Dependency	☐	☐	Recreational Drug Use			

I understand that withholding any information could seriously jeopardize my safety and I have answered truthfully to the best of my knowledge.

Signature:_____ Date:_____

I consent to a dental exam including X-rays, photographs, study models or other diagnostic aids deemed appropriate by the doctor to make a complete diagnosis of my current dental condition.

Signature:_____ Date:_____