Request for Fee for Service Dental Treatment

(Please fax to 478-746-1125)

Date ____________________

_____Patient would like to be scheduled and seen every six months for an exam, cleaning, and oral cancer screening with treatment as needed.
_____Patient would like to be seen as requested.
_____Patient would like to be seen for an Emergency Visit.

PATIENT

Name____

Facility ____

Social Security # ____________________________ Date of Birth__________________________

Medicaid ID: ________________________________

AUTHORIZED RESPONSIBLE PARTY

Name____

Relationship________________________________

Address ____

City _________________________ State ______________________ Zip Code _______________

Home Number ____________________________ Cell Number ____________________________

Work Number _____________________________ Email address ___________________________

Bill for Treatment should be sent to:
______Authorized Responsible Party

______Facility Trust Account Manager: If the bill goes to the FTAM please provide PO Box or address.

____

____

____

____

111 Grove Pointe Drive. Macon, Georgia, 31210.
Phone: 478-330-5038 Fax: 478-476-1125
dynamicmobiledentistry@gmail.com

IMPORTANT INFORMATION FOR OUR PATIENTS

FEE FOR SERVICE PATIENTS

Fee for Service Patients may be seen on a six month recall plan, as requested or needed, and/or on an emergency basis. If you have an emergency situation, please let the facility know or call our office at 478-330-5038.

PAYMENT OPTIONS

We accept checks and money orders. When possible please have payment ready at time of service. We understand this may not always be an option, so we will bill the responsible party. Please pay within 30 days.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and 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 multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have received 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 form time to time and that I may contact this organization at any time at the address above 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 or disclosed 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 not agree then you are bound to abide by such restrictions.

THANK YOU for understanding our policies. We appreciate the confidence you have placed in us. If you have any questions, please feel free to ask.

I have read the information contained in this letter and agree to its terms.

____ __________________

Signature of Authorized Responsible Party or Patient Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so. Date ____________ Initial _____