



Welcome to our practice!

Welcome to Wainright and Wassel DDS! We respect your time and would like to make your visit to our office as efficient as possible. Please review the following information regarding your dental care.

Hygiene Policy

Appointments for adults (18 years and older) will consist of a full mouth series of x-rays and a comprehensive exam (full mouth probing, education, and examination by the doctor). If you have had x-rays within the past 3 years, please bring them with you. If you cannot obtain your x-rays, new ones will be taken. Your *estimated* appointment time is 90 minutes. You will be scheduled for a cleaning on your following visit. We cannot guarantee a cleaning on your initial visit because we do not know all patients' particular hygiene needs before their examination.

Pediatric patients (under 18) will consist of a panoramic x-ray, 4 bitewing x-rays, a cleaning, and a comprehensive exam by the dentist. Your *estimated* appointment time is 60 minutes.

Patient Responsibility

We request that you complete all the patient registration and health history forms. Please bring these forms with you at your first scheduled appointment. Alternatively, you can mail them back to us at 6837 Falls of Neuse Rd, Suite 100, Raleigh, North Carolina 21615. It is your responsibility to have previous dental x-rays available at the time of your appointment. We reserve the right to take new x-rays if they could not be obtained, they are of poor quality, or they over 3 years old.

Dental Insurance

We will be happy to file your dental claim *as a courtesy to you* as long as you are able to provide us with *current* dental information as well as a copy of your insurance card. We will **NOT** be able to file your insurance without this information. Without your insurance information payment in full at the time of your appointment is your obligation. If you have secondary dental insurance you will be responsible for filing.

Payment Policy

We expect payment at the time of your appointment for your portion of the services performed, deductibles, and co-insurance. When checking out from your appointment, we will give you your *estimated* insurance coverage. The outstanding balance will need to be paid at the time of service. Regardless of your insurance benefits, payment for services remains your personal responsibility. Patients filing their own insurance will be provided with a full-itemized statement for their specific insurance company. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit (an interest free payment plan). Should you have any questions, please feel free to call our office.

Cancellation/Emergency Policy

Please notify us as early as possible if you are unable to keep your appointment. *A fee of \$55 will be charged for any appointment broken with less than 48 hours notice.* We provide 24 hour emergency service for our patients. Please be advised that there is a \$150.00 fee for after-hour visits in addition to any services rendered.

Thank you for your support of these policies. We look forward to providing you with the highest standard of dental care.



Understanding Dental Insurance

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

All levels of payment by insurance companies, including allowed fees, usual, customary, and reasonable (UCR) are governed by the premiums paid. They have nothing to do with the actual fee for the services rendered. Our fees are based upon a combination of our costs, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Thus, there is often a discrepancy between the amount covered under your policy’s UCR schedule, and the actual cost of the procedure. The discrepancy is the patient’s responsibility.

The treatment recommended by our practice is never based on what your insurance company will pay, as your oral health care and accompanying treatment should not be governed by your insurance company contract.

Thus, it should be understood that ***the dental insurance contract is between the insurance company and the patient.*** If you are unclear as to whether a particular procedure is covered by your carrier, please submit a pre-estimate for treatment before scheduling.

We hope this information has been helpful. Please take the time to review your insurance policy’s nuances thoroughly so that we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

SIGNATURE: _____

DATE: _____



Financial Agreement

As a condition of your dental treatment in this office, *financial arrangements must be made in advance*. This practice depends upon reimbursement from the patient and the insurance company for costs incurred in their visit at the time of service. Therefore, the patient must consider their financial obligation prior to the visit.

All dental services including emergency services must be paid at the time services are rendered.

Patients who carry dental insurance must understand that this practice will do our best in preparing your insurance forms or **assist in making collections from insurance companies* and will credit any such collections to the patient's account. However, our dental practice cannot render services on the *assumption* that our charges will be paid at 100% by an insurance company. Also, this office only accepts benefits from primary dental insurance claims. Claims for secondary insurance are the responsibility of the patient.

A service charge of 1 1/2% per month (18% annum) on the unpaid balance of any account will be charged to all accounts with balances over 90 days. Any unpaid accounts with balances past 90 days will be turned over to a collection agency and or an attorney in attempt to collect the remaining payment. All late charges are the sole responsibility of the patient.

Patients must understand that the fee estimate listed is just that, an **estimate**. Treatment plans developed in this practice are subject to change depending on the specific dental condition.

- *In consideration for the services rendered to me by the doctor, I agree to pay in full my estimated portion at the time of service (per the first paragraph). I also agree that I shall be responsible if a remaining balance exists once insurance has paid. I agree to pay all collection costs and attorney fees if a suit shall be instituted.*
- *I grant permission to you or your staff, to telephone me at any time to discuss matters related in this form.*
- *I have read and fully understand the above conditions of treatment and agree to its content.*

Signature

Date

*Please realize that we do file your insurance as a *courtesy* to you. Any questions/concerns regarding your claim is **your** responsibility to follow up on. We strive to provide you with timely and efficient service each time you visit our practice and in doing so your assistance is greatly appreciated.



Permission for Diagnostic and Treatment Procedures

I authorize Drs. Wainright, Wainright, and Wassel to perform diagnostic and treatment procedures, which in their judgment may become necessary while at the office of Wainright and Wassel DDS. If I require specialized and or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Wainright and Wassel DDS.

**Consent to the use and disclosure of health information
for treatment, payment, and healthcare operations**

I further understand that as part of my healthcare, the office of Wainright and Wassel DDS originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care treatment. I understand that information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Health Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Wainright and Wassel DDS reserves the right to change this notice and practices and prior to implementation will post a copy of the revised notice. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Wainright and Wassel DDS is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Wainright and Wassel DDS has already taken action in reliance thereon.

I fully understand and accept the terms of this consent.

Signature of patient or parent/guardian: _____

Date: _____



HIPPA - Patient Acknowledgement Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order 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 been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office 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, 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Patient Information (Confidential)

Full Name _____ Today's Date: _____

___ Male ___ Female SS# _____

Birthdate: _____ Home Phone _____ Cell Phone: _____

Address _____ City: _____ State _____ Zip _____

E-mail _____ I would like to receive correspondences via e-mail: ___ Yes ___ No

Check Appropriate Box: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

If Student, Name of School/College: _____ City: _____

Patient's or Parent's Employer: _____ Work phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name (circle one): _____ Employer: _____ Work Phone: _____

How did you hear about our practice? _____

Person to Contact in Case Of Emergency: _____ Relationship: _____ Phone: _____

How Can We Contact You Directly? _____ (cell, home, work, e-mail, etc.)

Responsible Party

Name of person responsible for this account: _____ Relationship: _____

Address: _____ Home phone: _____

Drivers License #: _____ Birthdate: _____ SS#: _____

Employer _____ Work Phone: _____

Is this person currently a patient in our practice? ___ Yes ___ No

**For your convenience, we offer the following methods of payment: Cash, Check, Visa, MasterCard, American Express, Discover, and Care Credit (interest free credit plan - ask us for details)*

Insurance Information

Name of Insured: _____ Relationship: _____

Birthdate of Insured: _____ Social Security # _____

Name of Employer: _____ Work number: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ ID #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____