WILLIAM G. EASTBURN, D.M.D
5368 ZEIGLER BLVD.
MOBILE, AL. 36608
Phone:(251) 344-2126 Fax:(251) 344-2168

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____Cell Phone_____Other_____

Birth Date_____Social Security #_____Email_____

If patient is a minor, give parent's or guardian's name_____
Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Name_____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

How long at this address_____ Home Phone:_____ Work:_____
Previous address (if less than 3 years)

_____
Street City State Zip

Social Security#_____Birth Date_____
Relationship to patient_____
Employer_____Occupation_____No. years Employed_____
Spouse's Name_____Relationship to patient_____
Employer_____Occupation_____No. years Employed_____
Social Security #_____Birth Date_____
Relationship to patient_____

INSURANCE INFORMATION

Insured's name_____Insured's Soc. Sec. #_____
Insured's Date of birth_____Insured's Employer_____
Insurance Company_____Group #_____Local #_____
Insurance Co. Address_____
Do you have dual coverage? Yes ☐ No ☐ If Yes:
Insured's Name_____Insured's Soc. Sec. #_____
Insurance Company_____Group #_____Local #_____
Insurance Co. Address_____
Insured's Employer_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____
Complete Address_____
House Phone:_____Cell Phone:_____

_____

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 48 HOUR BUSINESS DAY ADVANCE NOTICE THE FEE IS $100.00 PER BROKEN OR CANCELLED APPOINTMENT.

I understand that where appropriate credit bureau reports may be obtained.
Signature (parent's signature if minor)_____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. By signing this agreement, you authorize us to access your credit bureau report when appropriate. The following is a statement of our Financial Policy, Which we require you to read and sign prior to treatment.

All patients must complete our information and insurance form before seeing the doctor. **FULL PAYMENT IS DUE AT TIME OF SERVICE**. Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your **estimated** co-payment may be adjusted after the time of service depending upon the final reconciliation of the insurance benefit payment. WE ACCEPT CASH, CHECK, VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS AND DEBIT CARDS. In addition we have outside financing available.

PATIENTS WITHOUT INSURANCE:
Are required to pay 100% of the fee at the time of service unless other arrangements have been made.

PATIENTS WITH NON PPO INSURANCE:
In the event assignments of benefits are accepted we require 100% for service not covered by insurance and all deductibles and co-pays are paid at the time of service, unless other arrangements have been made. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is contract between you and your insurance company. We are not a party to the contract. Please be aware that some, and perhaps all of the service provided may be non-covered services and not considered reasonable and necessary by some insurance companies.

- Although we are willing to complete insurance information forms and submit claims on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- Our office will not enter into a dispute with your insurance company over claim, although we will provide necessary documentation your insurance company request to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and request of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

USUAL AND CUSTOMARY RATES:
Our practice is committed to provide 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. By accepting service from us you agree to pay the rates we charge for service. If you have any questions, reservations or dispute with the rate we charge for a particular service. You should discuss the matter with us before the service is rendered and not after. According to the National Dental Advisory Service 2004 fee survey, fees charged in this office are within the average fee cost for dental treatment in Mobile, Alabama. If you feel that your insurance company has inadequate benefits to cover the cost of dental treatment. You may request from your insurance company the survey information and date of survey. This may allow you to understand how it arrived at its "usual and customary rates", this may also explain to you why the insurance benefits are inadequate.

Signature:_____ **Date:**_____

MINOR PATIENTS:
The adult accompanying a minor and the parents or guardians of the minor are responsible for the payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan. Visa/Master Card/ Discover/American Express/Debit Card or payment by cash or check at the time of service has been verified.

MISSED APPOINTMENTS:
Unless canceled at least 48 hours in advance, our policy is to charge **$100.00** for each missed appointment. Please help us serve you better by keeping your scheduled appointment. After two missed appointments, an additional $100.00 cash deposit will be required 48 hours in advance of your third appointment in order to reserve your appointment. If this deposit is not received within 48 hours of your appointment time, your appointment will be given to the first patient that is in need of an appointment. Any money received to reserve an appointment will be applied towards the patients' bill for services that day, provided the patient keeps the appointment at its scheduled time. If the patient fails to appear for the appointment, the deposit will not be refunded or applied towards any balance or future appointments, but will be payment for the missed appointment. Due to the high request and limited availability for extended hour appointments, these appointment times are very valuable for patients and staff therefore the fee for **BROKEN APPOINTMENTS AND CASH DEPOSIT FOR EXTENDED HOUR APPOINTMENTS IS $200.00**

CHECKS RETURNED FOR NON SUFFICIENT FUNDS: There will be a $25.00 charge for each returned check. If you have a check returned we will expect future payments in cash or in certified funds.
INTEREST CHARGES: All accounts that have not been paid in full within sixty (60) days, unless other arrangements have been made, shall incur interest at the rate of 1.5% per month or 18% APR on any unpaid balance.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt to pay said fee, including any/all collection agency fees, (33.33%) attorney fees/or court cost, if such be necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:
You agree, in order for us to service your account or to collect monies that you may owe,
William G. Eastburn, D.M.D., INC. And/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

BY MY SIGNATURE BELOW, I HERBY AGREE THAT I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO BE BOUND BY ALL OF ITS TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR. I/WE HAVE READ THIS DISCLOSER AND AGREE THAT WILLIAM G. EASTBURN, D.M.D.,INC., ITS EMPLOYEES AND/OR AGENTS MAY CONTACT ME/US AS DESCRIBED ABOVE

_____ _____
Responsible Party Signature Date

NON-COVERED SERVICE POLICY

As your dentist, I want to provide you with your choice of dental services. There may be certain services that you select that are not covered by your Preferred Care dental contract. For service(s) not covered by your insurance contract you will be expected to pay the difference or pay for the service in full. For example, your contract will pay for an amalgam (silver) filling on a posterior tooth when a composite (tooth colored) filling is used. On certain crowns you will have an additional fee not covered by insurance for the special type of crown we will be providing. In some cases, a special type of denture is required. Insurance does not take into consideration a patient's special needs and pays for the basic denture. In addition, procedures that are considered cosmetic and are not covered by your insurance will be your responsibility for payment in full.

Let me reassure you that only services necessary and appropriate for your treatment and care will be performed. If you have any questions, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree, as indicated by my signature below, to pay for the services that are not covered or for which payment is not allowed by my contract.

_____ _____

Patient/Responsible Party Signature Date

DR. WILLIAM G. EASTBURN D.M.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I_____ have received a copy of this Office's Notice of Policy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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