Kid City Smiles **Adult Patient Registration**

Please Print

Patient Information

Name _____ Preferred Name_____
Last First Middle Maiden

Address_____ City_____ State_____ Zip_____
Number/Street

Mailing Address (if different)_____ City _____ State _____ Zip_____
Number/Street

□ Male □ Female Date of Birth ____/____/____ Age ____ □ Single □ Married □ Divorce □ Separated □ Widowed

Home Number (___) _____ Employer's Number (___)_____ Social Security Number_____

Cell Number (___)_____ Pager Number (___)_____ E-mail_____

Employer Name_____ Position_____

Employer Address_____
Number/Street City/State/Zip

Spouse Information _____ Date of Birth_____
Last First Middle

Address_____ City_____ State_____ Zip_____
Number/Street

Home Number (___) _____ Social Security Number_____

Employer Name_____ Employer's Number (___)_____ Position_____

Employer Address_____
Number/Street City/State/Zip

Responsible Party_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____
Number/Street

Home Number (___) _____ Employer's Number (___)_____ Social Security Number_____

Employer Name_____ Position_____

Employer Address_____
Number/Street City/State/Zip

Primary Insurance

Insurance Company_____ Group Number_____ Phone Number_____

Address_____ Relationship to Insured_____
Number/Street City/State/Zip

Insured Name_____ SS# _____ Insured ID#_____ DOB__/__/____

Secondary Insurance

Insurance Company_____ Group Number_____ Phone Number_____

Address_____ Relationship to Insured_____
Number/Street City/State/Zip

Insured Name_____ SS# _____ Insured ID#_____ DOB__/__/____

Other Information

Referring Doctor_____
Whom may we thank for referring you _____
Emergency contact/name/Phone Number_____
Nearest Relative/Name/Phone Number/Relationship (not living with you)_____
Family Members/Friends seen by us_____

_____ _____

Patient Signature (Guardian/Responsible Party) **Date**

Kid City Smiles ~ Financial Policy

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered.

- As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 90 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.

- *We do not file medical insurance.*

- Payment may be made by any of the following methods.

  Cash **Check** **Credit Card**

- Information is available upon request for third party financing through the following:

  Care Credit

If paying in full by cash or check when services are rendered, a 5% credit adjustment may be applied to your account.

- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance on my account.
- I authorize all insurance benefits paid directly to Kid City Smiles.
- If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Tabor Dental Associates or make payment immediately to Kid City Smiles.
- I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.
- A finance charge of 1.5%will begin to accrue after 90 days from the date of service on the unpaid balance of my account even though insurance may be pending.
- A fee of $30.00 will be incurred for each returned check.
- In the event that my account is turned over to a collection agency or attorney for collection, I agree to pay collection costs, attorney's fees, court costs, and interest from the date of treatment.
- I authorize this office to discuss my account with a spouse or responsible party.
- If the patient is a minor or adult using insurance of someone other than his/her own, I authorize this office to discuss this account with the subscriber of the insurance, parent, step parent or responsible party.
- By initialing, I am consenting for Use and Disclosure of Health Information, Authorization for Treatment and Acknowledgement of Receipt of Notice of Privacy Practices. _____(please initial)

_____ _____

Signature of Responsible Party Date

Mary Beth Tabor, DDS
107 Maple Row Blvd
Hendersonville, TN 37075
615.822.5588 615.822.3206fax

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. The Notice takes effect 11/01/2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for national copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and disclosures of health information.
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing actives.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information not the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Mary Beth Tabor, DDS
107 Maple Row Blvd
Hendersonville, TN 37075
615.822.5588 615.822.3206fax

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

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

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

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