Demographic & Patient Information

Prefix: □ Mr. □ Mrs. □ Ms. □ Dr.

First Name:_____ M.I._____ Last: _____

Gender: □ Male □ Female □ Other: _____ Birthdate: _____/_____/_____

Social Security Number: _____ - _____ - _____ Marital Status: _____

Email Address: _____

Mailing Address:

Street: _____ Apt: _____

City: _____ State:_____ Zip: _____

Telephone Numbers:

Home: (_____) - _____ -_____ Mobile: (_____) - _____ -_____

Work: (_____) - _____ -_____

Driver's License Number: _____ and State Issued _____

Whom may we thank for referring you to our practice? _____

What is your general dentist's name? _____

And their phone number? : (_____) - _____ -_____

What is your medical doctor's name? _____

And their phone number? : (_____) - _____ -_____

Do you have a medical specialist (Cardiologist, Hematologist, etc) , if yes, who _____

And their phone number? : (_____) - _____ -_____

Which Pharmacy do you use? _____ Location: _____

And their phone number? : (_____) - _____ -_____

Insurance Information

Primary *DENTAL* Insurance Information:

Subscriber's Name: _____

Subscribers Birthdate: _____/_____/_____ and their SSN: _____ - _____ - _____

Insurance Company Name: _____ Phone: (_____) - _____ -_____

Insurance ID#: _____ and Group #: _____

Employer Name: _____ and Phone : (_____) - _____ -_____

SECONDARY Dental Insurance Information (If applicable)

Subscriber's Name: _____

Subscribers Birthdate: _____/_____/_____ and their SSN: _____ - _____ - _____

Insurance Company Name: _____ Phone: (_____) - _____ -_____

Insurance ID#: _____ and Group #: _____

Employer Name: _____ and Phone : (_____) - _____ -_____

Primary *MEDICAL* Insurance Information:

Subscriber's Name: _____

Subscribers Birthdate: _____/_____/_____ and their SSN: _____ - _____ - _____

Insurance Company Name: _____ Phone: (_____) - _____ -_____

Insurance ID#: _____ and Group #: _____

Employer Name: _____ and Phone : (_____) - _____ -_____

SECONDARY Medical Insurance Information (If applicable):

Subscriber's Name: _____

Subscribers Birthdate: _____/_____/_____ and their SSN: _____ - _____ - _____

Insurance Company Name: _____ Phone: (_____) - _____ -_____

Insurance ID#: _____ and Group #: _____

Employer Name: _____ and Phone : (_____) - _____ -_____

Health History:

To our patients: Although oral & maxillofacial surgery is primarily concerned with the face and oral cavity, the mouth is connected to and is a part of your entire body. All health/medical issues, medications, surgeries, and social habits are important for us to know about. The information you provide is confidential, and so should be answered truthfully and to the best of your knowledge. Thanks.

What is your reason for visiting our practice? _____

Do you have and unhealed/recurrent injury, inflammation, growths, or sores in your mouth? …… Yes / No

Do you have any prosthetic or artificial joints? …….. Yes / No

Do you have any artificial heart valves or vascular grafts? …… Yes / No

Have you ever had any heart defects, damaged heart valves, or a history of endocarditis? ……. Yes / No

Have you ever had any organ transplants, or currently taking immunosuppressants or steroids?..... Yes / No

Do you take any blood thinners (Aspirin, Plavix, Coumadin, Eliquis, Vitamin E., Ginko, Pradaxa, and Xarelto)…. Yes / No

Has a physician or a dentist ever recommended that you take antibiotics before dental visits? …… Yes / No

Have you or a family member had any unusual or serious reactions to general anesthesia? ……. Yes / No

Do you currently (or have ever) smoked or used any tobacco products?..... Yes / No

Are you pregnant or nursing? ……..Yes / No

Have you ever taken any medications for your bones or Bisphosphonates such as Pamidronate (Aredia) Zoledronate (Zometa), Alendronate (Fosamax), Ibandronate (Boniva), Risedronate (Actonel)…… Yes / No

Please list all medical conditions, or problems with health: [ ] None - or-

_____

_____

_____

Please list all medications you are taking: [ ] None - or-

_____

_____

_____

Please List All Allergies (Drugs, medications, foods, environmental): [ ] None - or -

_____

_____

_____

Please list all surgeries/ procedures (medical & dental) that you've had, note the date and any complications:

_____

_____

Oral Maxillofacial Associates of Montclair Financial Policy

(Signature of the Financially Responsible Person Required. Minors are not allowed to sign this document)

We are committed to your successful treatment without additional worry about your financial obligations. The following is a statement of our financial policy, a legally binding document, which we ask that you read and sign prior to any visit in our practice.

General Clauses:

You should have a basic understanding of how your dental insurance works.

If we participate with your plan, and if your plan offers coverage/benefits for a procedure, our office will bill your account up to the maximum allowable negotiated fee as determined by your insurance company, and you will be reimbursed accordingly.

If your service is a covered benefit under your plan, the *insurance company may pay all or only a percentage* of that reduced/negotiated maximum allowable cost, and you are responsible for the remaining percentage/difference. Our office will do our best to settle claims and inquiries set forth by your insurance company, but after 90 days, the balance of your account statement will need to be paid in full. After 90 days, you may still receive a payment from your insurance company, but this is not a guarantee. After 90 days all accounts will accrue services fees and be sent to one of our collection attorneys.

Please understand that "participating" with a dental insurance plan (being In- Network) means only that your doctor has agreed to a negotiated and reduced fee for certain, and not necessarily all, services that we provide. It is your responsibility to determine if Dr. William G. Ranucci or Dr. Emil Cappetta participate with your insurance(s) and what your insurance will reimburse for your procedures. We will help you, of course, however specific clauses and changes to your policy are given to you the subscriber, not our office, so we are not privy to all necessary information to give you a 100% accurate estimate or guarantee of insurance payment. Again, while our office can provide an estimate of any co-pay or fee for service, this is not a guarantee that your insurance will pay anything towards any costs of treatment. It is your responsibility to know your insurance percentage coverage, co-pays and out of pocket costs. Whatever percentage of coverage you are responsible for (and thus any out-of-pocket costs towards that maximum allowable amount) is between you and the insurance company, based on the plan that you selected.

It is your responsibility to advise our office of any insurance payments or explanations of benefits (EOBs) you receive from your insurance company regarding your treatment.

Please be aware that some, or perhaps all, of the services provided may be non-covered services under your particular insurance contract, or may not be considered reasonable and necessary under your plan.

In those cases, you will be responsible for the non-reduced fee (our regular office fee schedule amount). Please be advised that if your doctor does not participate with your insurance carrier, you will be required to pay in full for any services rendered on the day of treatment, as determined by our regular office fee schedule. We will submit all claims and proper paperwork to your insurance company on your behalf, and your insurance company will usually send payment directly to you.

Payment in full is expected at the time of services rendered.

Medical Insurance:

Dr. Ranucci and Dr. Cappetta are *not* in network with any medical plans.

Medical insurance may be required by your dental insurance in order to complete their claims. If your dental insurance requires your treatment and claims to be submitted to your medical insurer before they consider the claim, we will submit all necessary information on your behalf and apply any payments toward your outstanding balance.

Certain services such as bony impacted wisdom teeth removal, jaw fractures, orbital fractures or large cysts/tumors may be eligible for reimbursement through your medical insurance; we can fill out a claim for your records, but you would need to submit to them for your own personal reimbursement should they decide to pay anything depending on the procedures and your out-of-network benefits.

Medicare, Medicaid, and State-Funded Insurance Plans:

Neither doctor participates with any Medicare, Medicaid, nor state funded plans. These Insurance plans will not pay for any portion of the services provided in this office. The patient will be responsible for the total cost of the treatment as determined by our regular office fee schedule. We are NOT able to submit claims to these insurance plans on your behalf either.

If you do not have insurance:

Patients without insurance are responsible for the full cost of treatment, as determined by our regular office fee schedule.

Patients with participating dental insurances ("In-Network") shall pay the amount of their estimated co-pay and deductible as determined by their plan's maximum allowable fee schedule at the time of service.

Other:

Again, all patient balances must be settled within 90 days of the date services are rendered. This is regardless of whether or not your insurance claim is in progress, pended, or finalized.

If your insurance has not paid their expected percentage of your balance within that 90 day period, you will still need to pay the remaining balance to our office, and await reimbursement. (see below).

After 90 days the patient is responsible to pursue payment from the insurance company.

We will assist you with this in any way we can, but it is not the responsibility of Oral Maxillofacial Associates of Montclair to finalize/settle any insurance claims before expecting full payment after 90 days from services rendered.

All current documentation can and will be provided by mail or email in order to assist any inquiries.

Any insurance reimbursements paid to us (after your bill is paid in full) will be remitted to you within 30 days of receipt by us.

Any charge not paid by your insurance because of incorrect primary insurance information, failure to submit proper insurance in a timely manner or coordination of benefits issues not handled with your carrier will be the financial responsibility of the patient.

We are not responsible if your insurance company decides any treatment does not qualify as a covered benefit due to deductibles, depletion of yearly funds/benefits, or any other plan provisions. These factors are determined by the insurance company and the particular plan you (or your group) selected.

Patient Acknowledgements:

Patients are responsible for the payment of their own account; you may designate insurance coverage through another person if you are a participant under his or her plan; however, you should understand that all financial responsibility remains with the patient [or the person signing this form].

Minors are unable to enter contractual agreements for their care and must be accompanied by a legal guardian, who shall assume the financial responsibility for the underage patient.

It is your responsibility to notify our office of change or loss-of-coverage with insurance, or any change to your billing address or the address where you wish to receive our correspondence.

You understand that the treatment recommended by our office is never based on what your insurance will pay. Rather, treatment is determined by the health and needs of each patient and his/her condition.

Appointment Policies:

Initial Consultations and Visits: Initial consultations/exams/visits and X-Rays are not complementary services. They are billable services, and these services may not be covered 100% by any insurance options that may be available to you. This means there could be an out-of-pocket expense at the conclusion of your initial visit.

Surgery Visits and Biopsy Visits: Payment is due at the time of surgery. This payment is reflective of the full cost of treatment and/or your portion of the fees (the copay) for those with insurance coverage for the procedure).

Biopsy appointments are usually not covered by any dental insurance plans, so patients should expect to see a fee from our office ($675) due at the time of the biopsy. Biopsies will also result in a separate bill/ service-fee from the lab or pathologist that examines the specimen under the microscope. That lab fee is usually (but not always) covered by medical insurance, partially or fully. Our office is not responsible for any fees billed to you for services rendered by the lab or pathologist.

Missed Appointments and Late Cancellations/Rescheduling Fees and Deposits:

A Missed Appointment (or Late Cancellation) is defined as either; not appearing for an appointment at all, arriving more than 20 minutes late for an appointment, or not formally canceling the appointment [by phone or via the cancellation form] within 24 hours of their scheduled appointment.

If a patient arrives 20 minutes or later for their scheduled appointment, the visit will need to be rescheduled, and will be considered a missed appointment and subject to a missed appointment fee (see below).

A $150 fee will be charged missed appointments and late cancellations for initial consults, office visits, or re-evaluations. Any deposit paid to hold your appointment for that visit will be not be reimbursed to you or go towards the costs of any future treatments; it will go towards the cost of the canceled or missed appointment.

The fee for any missed surgery appointments or those not canceled within 24 hours of the surgery appointment time is $750.

This $750 fee is irrespective of any estimated costs of the surgery, even if that estimate cost of surgery happens to be lower than the missed/late fee itself.

Fees for missed appointments and late cancellations/rescheduled visits will not be submitted for insurance reimbursement, and the patient (or guardian) is solely responsible for the cost. Any deposit paid to hold your appointment for that missed visit will be not be reimbursed to you or go towards the costs of any future treatments; it will go towards the cost of the canceled or missed appointment.

Payment Plans & Options:

We accept cash, check, debit, credit, Venmo, Stripe, Weave, as well as payments made through 3rd party payors such as Care Credit or Lending Club.

All credit card and debit card transactions, including services that utilize them such as Venmo, Weave, Sunbit, and Stripe, will incur a 4% surcharge and will be added to the total cost of your balance.

Service Fees, Counsel Fees, and Costs of Collection:

If any unpaid balances in your account are not reconciled within 90 days, your account will be considered delinquent. A delinquent account will automatically incur a $500 surcharge PLUS a 1.5% service charge every month (18% per year) until the balance is paid in full.

Any delinquent accounts can be sent to, processed, and managed by a collections agency or attorney for collection of balances owed to our office. In such case, you agree to be responsible to pay all of your remaining balance PLUS any collection fees, counsel fees, court fees or associated costs.

Collection fees will be at least equal to 35% of the amount of your outstanding balance, inclusive of interest.

Once your account is sent to collections, we are not able waive any fees or penalties associated with your account, nor are we able to contact the credit bureaus for any marring of credit or removal of financial liens

Insufficient Funds with Checks (Returned/"bounced" checks): A $50.00 fee will be applied for any returned checks.

Permission to Submit Insurance Claims on Your Behalf:

OMA of Montclair will require your permission to submit any and all insurance claims on your behalf by either postal service or electronically. You also grant permission for OMA of Montclair to submit any letters or disputes to the insurance commissioner's office, in an effort to collect maximum payment from my insurance companies for services rendered by Dr. William Ranucci or Dr. Emil Cappetta.

Authorization:

This signature below acknowledges and confirms my understanding and consent for the above mentioned statements. I also understand that I am financially responsible for all charges set forth unto me. This signature on file is also my authorization for the release of information necessary to process my claim. I hereby authorize payment to Oral Maxillofacial Associates of Montclair LLC., named of the benefits otherwise payable to me. I, the signatory of this form am over 18 years of age and accept the full financial responsibility for the person/patient on whom services are rendered. This contract and any other relevant and/or requested materials can be sent to any attorneys for the purpose of collecting payment.

Signature of the Person Accepting Financial Responsibility for the Patient Account (You must be over 18 years old to sign this document)

Your Signature:_____

Your Printed Name: _____

Your Birthday: _____

Name of the Patient on the Account: _____

Relationship to Patient on the Account: [ ] Self, [ ] I am their parent or guardian

Date: _____

Oral Maxillofacial Associates of Montclair

Health Insurance Portability and Accountability Act (HIPAA) Information and Agreement

The Doctors and Staff at Oral Maxillofacial Associates of Montclair are committed to maintaining the confidentiality of your personal, financial, and health information. State and Federal Law requires us to inform you of our policy and practices as long as we provide you services.

How we protect your personal information:

We authorize individuals to access your personal information only to the extent necessary to conduct our business of serving you, such as making and confirming appointments, submitting insurance claims, securing insurance benefit information, and submitting applications for third party payment arrangements per your request. We take steps to secure our building, patient files, and electronic systems from unauthorized access. Our employees are trained regarding confidentiality and are held to strict office policy and procedures regarding your personal and health information both written & verbal. All employees are subject to discipline if they violate these procedures.

Information we share:

We may share your personal or health information with other third parties with or without authorization for our normal business functions. Examples of our normal business functions include:

Submission of Medical & Dental Claims

- Letters or X-ray transmission to your General Dentist or Referring Doctor Submission for laboratory analysis or biopsy specimens & reports
- Referrals to another specialist or for a second opinion
- Requests to or from pharmacies
- Processing transactions that you request
- Appointment notification via voice messages, or other written or verbal means
- In cases regarding accidents or workman's comp, provide appropriate lawyers with information regarding your case.
- Submitting a letter to the insurance commissioner in an effort to get prompt payment from your insurance carrier for services rendered in our office.

Patient Rights:

We honor your right to request access to your personal information. To do so, you must submit a written request describing the information you are requesting. There will be a $5.00 charge for staff time to retrieve and copy the requested information plus postage. If we are unable to locate and retrieve the information within 30 days from your request, we will inform you of the nature and substance of the personal information either in writing or by telephone. If access is granted we will permit you to see and copy in person, the requested information only or to obtain a copy by mail, whichever you prefer. *If you are denied access to your health information you may ask the denial be reviewed.* You may refuse to consent to the use of disclosure of your personal information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to disclose your personal health information to us.

Final Consents and Authorizations:

- I, hereby acknowledge that I read and understand The Health Insurance Portability and Accountability Act (HIPAA) Information and Agreement by OMA of Montclair above. I have been given the opportunity to ask questions regarding this notice.
- I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of the staff, responsible for any errors or omissions that I have made (whether accidentally or intentionally) in the completion of this form.
- I have read and reviewed all pages of the OMA of Montclair Financial Policy
- I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment**.** This authorization extends unto myself and to any minor under my care that seeks services at OMA of Montclair.

_____ _____/_____/_____

Signature of Patient or Legal Guardian (If patient is a minor): Date