North Shore Dental Center

Hiam Elias, D.M.D., PC
Suite 302
6 Essex Center Drive
Peabody, MA 01960
978-532-0088

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment is considered part of your treatment. The following is a statement of our financial policy that we require that you read and sign prior to any treatment.

- All patients must complete a *Health History, HIPPA Consent and Patient Information form* prior to treatment.

I. Insurance:

Please bring all of your dental insurance information. Our office will submit claims pertaining to your treatment. Co- payments and deductibles will be collected at time of service. You are responsible for the balance of payments not covered by your insurance company. Some insurance plans base the amount of reimbursement on a fee schedule developed by the insurance company. For this reason, you may receive a lesser percentage of reimbursement.

II. Usual & Customary Fees:

Our practice is committed to providing the very best treatment for our patients. Our fees are based on the treatment plan you select, the time it takes to provide you with the necessary care and the office expenses related to that treatment.

III. Adult Patient:

Adult patients are responsible for payment at time of service.

IV Minor Patient:

The adult accompanying a minor shall be responsible for authorization of treatment and for payment of service. Unaccompanied minors will receive only emergency treatment unless prior authorization and payment for treatment has been previously arranged.

V. Missed Appointments:

Unless canceled at least 24 hours in advance, our office could charge a fee for a missed appointment. Please help us to serve you better by keeping scheduled appointments.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date

PATIENT INFORMATION FORM

A. Patient's Name:_____

If a minor, parent/ guardian name: _____

B. Employer _____

Employer Address _____

Do you have dental insurance? YES NO (if no, skip down to Part C)

Subscriber's Name _____

Employer's Name & Address _____

Insurance Company Name _____ Policy/Group #_____

Address_____

Social Security Number of Subscriber _____D.O.B_____

Secondary Insurance_____Policy/Group Number _____

Spouse's name _____D.O.B. _____

Spouse's Employer & Address _____

C. If you do not have insurance, how would you like to pay for treatment?

Cash Check Credit Card

Previous Dentist's Name _____

Address _____ Phone Number _____

Whom may we thank for referring you? _____