Fultondale Dental Care
Family and Cosmetic Dentistry
Casey M. Bloom, D.M.D., L.L.C.

1810 Decatur Highway
Suite 212
Fultondale, Alabama 35068
Phone: (205) 849-0676
Fax: (205) 849-9533

Patient Information

Date ____________ Home Phone (____) ____________ Cell Phone (____) ____________

Name ____________ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # ____________

Address ____________ E-Mail ____________

City ____________ State ______ Zip ____________

Sex ❑ M ❑ F Age ______ Birthdate ____________ ❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced

Patient Employer/ School ____________ Occupation ____________

Employer/School Address ____________ Employer/School Phone (____) ____________

Whom may we thank for referring you? ____________

In case of emergency who should we contact? ____________ Phone (____) ____________

Primary Insurance

Person Responsible for Account ____________ (Last Name / First Name / Middle Initial)

Relation to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address (if different from patient's) ____________ Phone (____) ____________

City ____________ State ______ Zip ____________

Person Responsible Employed by ____________ Occupation ____________

Business Address ____________ Business Phone (____) ____________

Insurance Company ____________

Contract # ____________ Group # ____________ Subscriber # ____________

Names of other dependents covered under this plan ____________

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ____________ Birthdate ____________ Relation to Patient ____________

Address (if different from patient's) ____________ Phone (____) ____________

City ____________ State ______ Zip ____________

Subscriber Employed by ____________ Business Phone (____) ____________

Insurance Company ____________ Soc. Sec. # ____________

Contract # ____________ Group # ____________ Subscriber # ____________

Names of other dependents covered under this plan ____________

Please Complete Both Sides

Dental History

Reason for Today's Visit ____________ Date of last dental care ____________

Former Dentist ____________ Date of last dental X-rays ____________

Address ____________

Check (✔) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? ____________ How often to you brush? ____________

Medical History

Physician's Name ____________ Date of last visit ____________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe ____________

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates ____________

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (4) if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistant
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophelia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV, AIDS
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

MEDICATIONS

List medications you are currently taking:

____

____

ALLERGIES

____

____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with ____________ (Name of Insurance Company(ies)) and assign directly to Dr. ____________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance documents.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____________ Signature of Patient, Parent, Guardian or Personal Representative

____________ Date

____________ Please print name of Patient, Parent, Guardian or Personal Representative

____________ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

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Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Our fees are reasonable and customary in accordance with other specialist offices in this area. In case of financial hardship please discuss financial arrangements with the office manager prior to being seen. Our financial policies are in compliance with our office policy. The following is intended to provide a clear understanding of our Financial Policy and your financial responsibility.

Payments: We accept cash, debit cards, Visa, Mastercard , American Express, Discover, Care Credit and personal Checks with a photo ID. After services have been rendered, we will bill your insurance company and any outstanding balances are due within 30 days.

Re-biling Fees: A re-billing fee of 22 % interest will be imposed on each account that is over thirty (30) days past due. We determine your account is past-due by taking the balance owed thirty (30) days ago and then subtracting any payments or credits applied to your account during the time. Unless other arrangements are approved in writing, your account will be billed a re-billing fee. This is an attempt to control the costs associated with sending several statements.

Insurance: Remember, Your insurance is a contract between you and your insurance company. Dr. Casey Bloom is not responsible for your deductibles, co-payments, co-insurance, percentages, non-covered services or services rendered without proper referral authorization, or denied services. If we are providers for your insurance company we will bill your insurance and collect only the patient responsible portion of your bill. Our office policy is to file your initial primary and secondary claims for services rendered. Please remember, if your insurance denies payment, it is your responsibility to pay your bill and contact your insurance regarding the denial of the claim.

We will not change diagnosis codes in order to get your claim paid unless it is documented in the chart by your doctor, as it is illegal to do so. If your insurance does not cover certain procedures or office visits, the dispute remains between you and your insurance company.

Insurance Deadlines: Many insurance companies have *Timely Filing Deadlines.* It is your responsibility to inform us of any insurance changes. If we are not provided with accurate information at the time of service, you may be responsible for the payment in full for all services rendered. It is the patient's responsibility to know if Dr. Casey M. Bloom is a valid provider with your insurance company.

Regarding Out-Of-Network: We try to verify all patient's insurance benefits before you are seen by the doctor and this takes time. So please be patient with us. If you are out of network and still want to be seen by the physician, please be advised that you will be responsible for the full amount that your insurance doesn't pay at the time of the visit.

Co-Payments: All co-payments are expected at time of service and may be asked for prior to seeing the physician. When you sign with your insurance company, you signed an agreement between you and your insurance company stating co-payments are due at time of service.

Returned checks: All returned checks will be assessed a 47.00 return check fee. You will have 10 days to pay back the outstanding check and the return check fee. If you do not pay the check and the return fee in the specified time, the check will be sent to a collections agency. In addition, we only will accept cash or credit card for any future visits.

Collections Agency: Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement maybe assessed a 22% interest Rebilling Fee. All balances reaching 90 day past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees our office incurs through the process utilized to collect the delinquent balance.

Transferring of Records: You will need to request, in writing, the transfer of your records and allow 48 hour notice before records will be available- copies of your records will be sent to another doctor or organization.

List of Fees not covered by insurance:

1. Re-billing of statements: 22% Interest.
2. Returned checks:45.00and the amount of the check.
3. Late cancellation or no show for office visit: 50.00
4. Collection agency fees: Max. allowed by law.-to be determined by amount of collection fees.

I have read and agree to the above policy. I understand that I am financially responsible for all charges incurred by me for medical services rendered to me by Dr. Casey M. Bloom. I realize my insurance may not pay as much as I anticipate. Furthermore, I understand my entire account balance is due within sixty (60) days from the filing of my claim, unless other arrangements have been made prior to any treatment.

PATIENT'S RIGHTS AND RESPONSIBILITIES

RIGHTS:

1. You have the right to receive courteous, quality health care.
2. You have the right to have health information written so you can easily understand it.
3. You have the right to have your medical records and other information about your treatment kept confidential, unless the law requires us to release it.
4. You have the right to know and understand any diagnosis, treatment or prognosis made by your doctor.
5. You have the right to refuse to accept services or complete treatment recommended to you by your doctor.
6. You have the right to file a complaint with your doctor and receive a timely response.

RESPONSIBILITIES:

1. Your are responsible for treating Dr. Casey M. Bloom and his staff considerately.
2. You are responsible for providing accurate information to your doctor.
3. You are responsible for keeping your doctor informed about any changes needed on your Medical records.
4. You are, if applicable, responsible for contacting Dr. Casey M. Bloom and following his instructions prior to seeking further medical care. Dr. Casey M. Bloom will then coordinate any additional care that may be necessary.
5. You are responsible for abiding by the polices set forth by this office.
6. You are, if applicable, responsible for abiding by the policies set forth by your insurance carrier.
7. You are responsible for calling our office if you have a question or problem.
8. You are responsible for keeping your doctor informed about your health and anything that may affect your treatment.

Missed Appointments/ Late Cancelation Fees

We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request you notify our office 24 hours in advance. When an appointment is missed or cancelled with less than 24 hours of notice, you are hurting more than yourself. We cannot offer this appointment to another patient if you already are scheduled and the other patient cannot be seen until the next available opening. So if you do not call within 24 hours notice or just do not show up for the appointment, there will be a fee for this appointment applied to your account.

Notice Of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used 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 assessment and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization 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 treatment, payment or healthcare 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.

Acknowledge of receipt of Notice of Privacy Practices (HIPAA)

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below:

- (yes) or (no) may be notified by telephone of pending office visits.
- (yes) or (no) office may call you at home with lab and/or other test results.
- (yes) or (no) pharmacy refills can be called or faxed to your pharmacy.

Person(s) and telephone number(s) of patient's medical information may be given to (spouse, daughter, son, or any other friend or relative).

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- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, to the attention of the Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to a re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition my treatment or payment on providing this authorization, except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide the research-related treatment.
- ( ) If this box is checked, I understand you will receive the compensation from a third party for the use or disclosure of my information.
- I understand all of the above regarding Acknowledgement of receipt of Notice of Privacy Practices,Financial Policy, Patient's Rights and Responsibilities, Missed Appointments, and Late Cancellation Fees.

______________________________ ______________________________

Patient Date