Office Policies/Dental Insurance/Private Pay

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment is due at the time of services rendered.

If you have insurance, the checks get sent directly to you. Payment is due at the time of services rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover and Care Credit. We will be happy to help you process your primary insurance claim form for reimbursement. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We must emphasize that as dental care providers our relationship is with you not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If payment problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

1. Payment at each visit when services are rendered.
2. One-half in advance with the remainder to be paid in full at the final visit (if over $200.00 for proposed treatment plan-two appointments.)
3. One-third at the start of treatment, one -third during treatment and one-third upon completion of treatment. (If treatment requires more than two appointments.)
4. Care Credit

Divorced parents bringing a child to an appointment are solely responsible for all fees incurred during each visit. Parents will not be billed separately.

Returned checks will be subject to a $35.00 NSF fee. Balances older than 30 days will be subject to additional collection fees. A $45.00 fee may also be added to your account for broken or cancelled appointments without 48 hours notice. This fee also applies to patients who neglect to take their pre-medication.

If you have any questions about the above information or uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you.

Sincerely,

Phillip C. Yancho, D.D.S.
And Team

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence;
2. A review entity's functions;
3. A claim for payment of fees;
4. A third party payer's examination of our records;
5. A court order as part of a criminal investigation;
6. An identification of a dead body;
7. A licensure investigation; or
8. A child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

For office use only

☐ Patient Refused to Sign

☐ The following circumstances prohibited the patient from signing the Acknowledgment:

☐ An emergency situation prevented the patient from signing the Acknowledgement.

_____
Office Personnel (signature)

_____
Office Personnel (print name)

Date: _____

_____
Patient Signature

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

_____
Patient Name (please print)

Date: _____

PATIENT CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____
Patient Signature

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

_____
Patient Name (please print)

Date: _____

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Check

Do you have a specific dental problem? Describe _____ ☐ Yes ☐ No
Do you think you have active decay or gum disease? _____ ☐ Yes ☐ No
Do you brush and floss on a routine basis? Discuss _____ ☐ Yes ☐ No
Do your gums ever bleed? Discuss _____ ☐ Yes ☐ No
Do you like your smile? Why? _____ ☐ Yes ☐ No
Does food catch between your teeth? Any loose teeth? _____ ☐ Yes ☐ No
Do you want to keep your remaining teeth? _____ ☐ Yes ☐ No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ ☐ Yes ☐ No
Have your past experiences in a dental office always been positive? _____ ☐ Yes ☐ No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ ☐ Yes ☐ No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ ☐ Yes ☐ No
Have you ever been hospitalized or had a major operation? Discuss _____ ☐ Yes ☐ No
Have you ever had a serious injury to your head or neck? Discuss _____ ☐ Yes ☐ No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ ☐ Yes ☐ No
Are you on a special diet? Discuss _____ ☐ Yes ☐ No
Are you allergic to any medications or substances? Please check box below _____ ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ ☐ Yes ☐ No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery *	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder *	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt *	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis *	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen? *	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐				Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss _____ ☐ Yes ☐ No
Do you wish to talk to the dentist privately about any problem? _____ ☐ Yes ☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

_____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTION		PATIENT'S SGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

PATIENT INFORMATION

Date: _____

NAME _____ (LAST) _____ (FIRST) _____ (M) ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

SOCIAL SECURITY # _____

ADDRESS _____ (STREET) _____ (APT. #) _____ (CITY) _____ (STATE) _____ (ZIP)

BIRTH DATE _____ (MONTH) _____ (DAY) _____ (YEAR) TELEPHONE _____ (HOME) _____ (WORK) _____ (CELL) _____ (E-MAIL)

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST _____ FIRST _____ M _____

STREET _____ CITY _____ STATE _____ ZIP _____

HOME _____ WORK _____ CELL _____ E-MAIL _____

BIRTHDATE (MO/DAY/YEAR) _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ DENTAL INS. CO _____

SS # _____ SUBSCRIBER # _____ GROUP # _____

SECONDARY INSURED

LAST _____ FIRST _____ M _____

STREET _____ CITY _____ STATE _____ ZIP _____

HOME _____ WORK _____ CELL _____ E-MAIL _____

BIRTHDATE (MO/DAY/YEAR) _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ DENTAL INS. CO _____

SS # _____ SUBSCRIBER # _____ GROUP # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The informationon this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____
Patient or Responsible Party

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

_____ (Date) _____ (State Driver's Licence #)

Has any member of your family ever been treated in our office?

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office

☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

Card # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp.date _____

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

Our system runs on a 15 day billing cycle and the payment is expected within 10 days of receiving the statement. If a second statement is sent, a service fee of $15 will be added to your account. In the case of default of payment, you promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION/RESPONSIBILITY AGREEMENT

I have requested Dr. PHILLIP C. YANCHO to bill my insurance company (for covered services), if insurance applies, on my behalf. I clearly understand that whether I have insurance **or not** all services will be paid in full at the time of each visit. If the account is sent to a collection agency, I agree to pay all fees incurred by the agency.

I hereby authorize all insurance companies, **if insurance applies**, to release payment only to the subscriber. Please be sure and verify with your insurance company your benefit year and your maximum coverage for the benefit year. Dr. Phillip C. Yancho is not responsible for any misinformation, denials, or nonpayment from your insurance company. A copy of this can be considered as an original for insurance purposes.

I have read and agreed to abide by all written office policies.

SIGNED _____ Date: _____

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

Print Name _____

Patient's Business Phone Number (or best number to be reached at during the day) _____

3699 S. Airport Rd. W.
Traverse City, MI 49684

FAX: 231-941-5640

TEL: 231-941-2201

Phillip C. Yancho, D.D.S.
Cosmetic & Family Dentistry

Phillip C. Yancho, D.D.S.
3699 South Airport Rd W
Traverse City, MI 49684
(231) 941-2201

In order to transfer your dental records, we must have your written permission. Please fill out the following form completely, sign, and return to the dental office in which your previous records are held.

RELEASE FORM

Patient Name: _____

- Please cancel all of my future appointments.
- I understand that I am responsible for any outstanding balance on my account.
- I authorize the release and transfer of my dental records to the office of Dr. Phillip C. Yancho.
    - Please email my current records to: scheduling@yanchodentistry.com

Signature: _____ Date: _____

Please complete and submit the form without a signature. You will be able to sign the form when you arrive at the office.

Parent or Guardian: _____ Date: _____

ubmit by Ema Print Form