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We would like to take this opportunity to welcome you as a patient and to thank you for choosing Mike Morton Dentistry. Your dental health is our top priority and we are honored to provide you with exceptional dental care. In order to help make your first visit a convenient and pleasant experience, please take the time to complete the attached paperwork prior to arrival. Also, **please arrive 15 minute early to your appointment** so that we may verify your dental benefits if needed.

Missed Appointment Policy

When we schedule an appointment, a specific amount of time is reserved especially for you. If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hours notice** so that we may offer that spot to someone else. If you cancel you appointment with less than 24 hours notice, or miss an appointment, a fee of $30 will be applied to your account. Multiple missed or short notice cancellations may result in no future appointments being scheduled.

Late Arrival Policy

When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.

I have read the policy above. I understand and agree to abide by the listed terms.

Date_____Patient Signature_____

Mike Morton, DDS

Financial Responsibility Form

Patient name: _____

If Patient is under the age of 18, name of the individual who is financially responsible for patient:

_____

If you do not have dental insurance, payment is due at the time services are provided.

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update our office at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to our office from your insurance company.

We do accept payments from the dental insurance companies; however, we are not contracted with many of them. It is a contract between you, your employer and the insurance company. We will provide you with an ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided. Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, and additional collection fees will be applied to any unpaid balance.

Any attorney or collection fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and attorney fees.

Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $25 NSF check fee and may also subject you to court costs and attorney fees.

I acknowledge having read this Financial Responsibility form in its entirety and agreed to be bound by all the terms and conditions herein.

Date_____Patient Signature_____

Mike Morton, DDS

HIPPA AUTHORIZATION

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name_____

I authorize Dr. Mike Morton Dentistry to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information being released:

2. To whom may the information be released (names or classes of recipients):

3. The purpose for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relation to the individual or purpose for the release:

It is your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date_____Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient _____Print name_____

Source of authority_____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00