Morristown Oral Surgery & Implantology Associates

PATIENT REGISTRATION FORM – Page 1 of 7

◈ PLEASE PRINT CLEARLY, READ CAREFULLY & FILL IN ALL ENTRIES ON PAGES 1-4 ◈

Patient's Last Name	First Name	MI	☐Mr ☐ Ms ☐Dr ☐Miss ☐Mrs
Street Address	City	State	Zip

Home Phone	Cell Phone	Work Phone
Social Security No. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth	Marital Status ☐S ☐M ☐D ☐W

Your Dentist	Email address:
Have you or a family member ever been a patient in our office? ☐ YES ☐ NO	Pharmacy Name and Telephone # _____

HEALTH QUESTIONNAIRE

➡ **Please review carefully and check *EVERY* item either "YES" or "NO"** (Do not leave blanks.) ⬅

YES	NO	***Have you ever had any of the following?***	YES	NO	***Have you ever had any of the following?***
		AIDS/HIV/other STD			High Blood Pressure
		Arthritis/Swollen Ankles/Joint Disease			Joint Surgery or Joint Replacement
		Asthma			Kidney Problems
		Blood Disorder (Anemia)			Liver Disease (Hepatitis/Jaundice)
		Convulsions, Seizures, Stroke			Lung Disease (TB /Emphysema)
		Are You on Dialysis?			Osteoporosis/Osteopenia
		Diabetes or Low Blood Sugar			Prolonged Bleeding/Bruise Easily?
		Drug or Alcohol Abuse			Cancer/ Radiation/ Chemotherapy
		Eye Disease/Glaucoma			Rheumatic Fever
		Heart Murmur			Sleep Apnea or Snoring
		Heart Trouble/Irregular Heart Beat			Thyroid Disorders (Hype or Hypo)
		Heart Surgery/Pacemaker			Mental Health Problems/Anxiety/Depression

List any other conditions of which we should be aware.

If you are under the care of a physician, list reason(s).

List any medications you are taking. ☐ COUMADIN, XALRETO OR ELEQUIS? ☐ IV-Zometa, Aredia, Reclast or Evista

[use reverse side if needed]

Check if you have ALLERGIES to: ☐ PENICILLIN ☐ LOCAL ANESTHETIC ☐ IODINE ☐ LATEX ☐ SOY PRODUCTS

List other medication allergies: _____

YES	NO		YES	NO	
		Do you wear dentures?			*Women:* Are you/could you be pregnant?
		Do you wear contact lenses?			*Women:* Do you take oral contraceptives?
		Do you use tobacco products?			Are you taking or have you ever taken bone density Meds? Denosumab, Fosamax, Boniva, Actonel
		Do you take antibiotics before your dental visits?			
		Have you had ANYTHING to eat or drink in the last 8 hours?			

PATIENT'S SIGNATURE ***(If under 18, parent must sign)*** ➡ SIGN HERE

Date

Continue to next page…..

 Print Patient's Name _____

ABOUT YOUR INSURANCE – PLEASE READ CAREFULLY

◤IT IS YOUR RESPONSIBILITY TO KNOW THE CONDITIONS/LIMITATIONS OF YOUR INSURANCE◥

- Treatment recommendations are based on your needs and not on your insurance coverage.
- Upon your request, the doctor can provide you with an estimate of our fees for your procedure if you've chosen to have an in-office consultation prior to scheduling the procedure. You can send the estimate to any insurance carrier for their response prior to scheduling your surgery. Your insurance company's estimate of payment or benefit is not guaranteed and can only be finally determined after your procedure is performed. WE CANNOT CALL YOUR INSURANCE CARRIER FOR YOU; however, we will complete an insurance form for you and will reply in writing to any correspondence they forward to us following your consultation. Our fee for a consultation is $140-275; our fee for each x-ray is $40-190 which may or may not be covered by your insurance depending on your policy. **PATIENTS SHOULD ALWAYS CONTACT THEIR CARRIERS DIRECTLY TO DETERMINE THEIR COPAYS.**
- Your insurance may not cover certain services (e.g., including, but not limited to, some types of lesions, IV sedation, general anesthesia, nitrous oxide, other exclusions from your plan). **Dr. Fang/ Dr Keiser do not appeal non coverage, and changes to insurance coding cannot be made. Treatment is *solely the patient's choice*.**
- Insurance benefits and services covered depend on the terms of the contract negotiated by you or your employer and the insurance company. ***Even within the same insurance carrier, very different contract terms can be chosen by the purchaser of a particular plan.***
- Neither the doctor nor the staff can determine what your insurance company will pay or even offer an opinion on how an insurance company will finally adjudicate a claim nor can they make assurances,

We do participate with Aetna Dental PPO & DMO, Ameritas Dental PPO, Cigna Dental PPO & Advantage, Delta Dental PPO, DenteMax, Guardian DentalGuard PPO, Healthplex PPO (4A/4G/28A/31A/32A) Horizon Dental Traditional & PPO, Humana Dental PPO, MetLife Dental PPO, Principal Dental PPO, TriCare Dental PPO, United Concordia Dental PPO, United HealthCare Dental PPO. (Plus many Discount Savings Plans)

➢ IF DR FANG and Dr. Keiser PARTICIPATE WITH YOUR DENTAL INSURANCE ➢

If you have dental insurance in which we participate, we file your insurance forms; however, you must follow up with all of your carriers to insure they process your claim(s) within 31 working days. Note: You are responsible for our full fee *(not an insurance company "negotiated fee")* for treatment which is not covered by your plan in accord with New Jersey Law. Most carriers have a limited time in which a claim can be submitted; therefore, the information you provide must be 100% **legible, complete, and accurate** to enable correct processing of your claim to avoid penalties against you such as negating your coverage.

PATIENTS WHO HAVE INSURANCE COVERAGE WITH THE CARRIERS IN WHICH WE PARTICIPATE (LISTED ABOVE) MUST FILL IN ALL INFORMATION ON THEIR INSURANCE(S) BELOW IN ORDER FOR US TO FILE YOUR CLAIM !!

[IF YOU DO N O T HAVE INSURANCE WITH A CARRIER NOTED ABOVE, CONTINUE TO THE NEXT PAGE.]

Dental Insurance

➪ALL entries below must be LEGIBLE, ACCURATE & COMPLETE!

Insurance Company: _____
Their Full Address: _____
_____
Name of Ins. Subscriber _____
Address of Subscriber _____
Subscriber's Date of Birth _____
Subscriber's Group No. _____
Subscriber's ID No. _____
Subscriber's Relationship to Patient _____

Medical Insurance

➪ALL entries below must be LEGIBLE, ACCURATE & COMPLETE!

Insurance Company: _____
Their Full Address: _____
_____
Name of Ins. Subscriber _____
Address of Subscriber _____
Subscriber's Date of Birth _____
Subscriber's Group No. _____
Subscriber's ID No. _____
Subscriber's Relationship to Patient _____

Continue to next page…..

 Print Patient's Name _____

ABOUT YOUR INSURANCE – PLEASE READ CAREFULLY *(continued)*

⮜ IF DR FANG DOES N O T PARTICIPATE WITH YOUR DENTAL INSURANCE ⮞

If you have dental insurance coverage with a company **other than** Aetna Dental PPO and DMO, Ameritas Dental PPO, Cigna Dental PPO & Advantage, Delta Dental PPO, DenteMax, Guardian DentalGuard PPO, Healthplex PPO/4A,28A,31A,32A,4G, Horizon Dental Traditional & PPO, Humana Dental PPO, MetLife Dental PPO,TriCare Dental PPO, United Concordia Dental PPO, United Healthcare Dental PPO or you do not have any dental insurance, ***PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.*** We will provide forms for you to submit for reimbursement for any dental insurance benefits you have. If you have insurance without out-of-network benefits, your insurance carrier may not reimburse you at all.

⮜ REGARDING MEDICAL INSURANCE FOR ALL PATIENTS ⮞

We do not participate with medical insurance. If you would like to confirm your out-of-network coverage, it is your responsibility to contact your carrier after a consultation. Certain types of oral surgery (e.g., some types of growths) may or may not be covered by medical vs dental insurance. We will provide forms for you to submit for pre-determination (estimate) by your carrier if you request it at a consultation appointment. If you do not have out-of-network benefits (e.g. DMOs), your carrier may not reimburse you at all. If the services of an oral pathology lab or diagnostic imaging provider—separate entities from this office—are required, they will bill you directly, and we are not involved in their insurance participation.

We do not participate with Medicare; therefore, cannot complete Medicare forms. Medicare does not consider tooth-related charges; and since we do not participate with Medicare, even if you are having services that are non-tooth related (e.g., treatment for some types of growths, charges from outside labs, diagnostic imaging, medications) which may be considered by Medicare, you will be responsible for our full fee at the time of service, and Medicare and Supplements will not reimburse you for any of our charges nor charges from other entities relating to or recommended as a result of your treatment here.

PAYMENT INFORMATION – PLEASE READ CAREFULLY

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

If you do **NOT** have dental insurance or have dental insurance in which Dr. Fang/ Dr. Keiser do **NOT** participate, payment in full is due at the time of service via Cash, Check, or Credit Card **(3% service charge if you use credit cards)**

✦ SPECIAL NOTE ✦

FOR THOSE WHO HAVE DENTAL INSURANCE IN WHICH WE PARTICIPATE, YOUR CREDIT CARD INFORMATION MUST BE ENTERED IN THE BOX BELOW FOR YOU TO BE SEEN TODAY.

If We participate with your dental insurance, **your ESTIMATED copay is due at the time of service**. Since we do not balance bill nor offer "payment plans," your credit card will be automatically charged or credited for any adjustments necessary after your claim is finally adjudicated on the day we receive the final Explanation of Benefits from your dental insurance carrier(s). We can forward a pre-determination of benefits to your carrier for their approval following your in-office consultation prior to scheduling an appointment for your procedure to provide you with your estimated procedure copay.

❖ For your Visa/MasterCard/Discover/American Express information ⮧

__ __ __ __ -- __ __ __ __ -- __ __ __ __ -- __ __ __ __ _____ _____

CREDIT CARD NO. *EXPIRATION DATE* *SEC CODE*

I authorize Morristown Oral Surgery & Implantology Associates to charge my credit card for all services rendered within one year of the date noted on the signature line below in accordance with this Contract.

Your Signature/Date: _____ _____

Signature *Date*

Clearly Print Name of Signatory Credit Card Holder _____

 Print Patient's Name _____

PAYMENT INFORMATION – PLEASE READ CAREFULLY *(continued)*

ALL ENTRIES MUST BE FILLED IN AND FINANCIALLY RESPONSIBLE PARTY MUST SIGN BELOW.

Name of Financially Responsible Party			Relationship to Patient:
Street Address	City	State	Zip
Home Phone / Cell Phone	Work Phone	Marital Status ☐S ☐M ☐D ☐W	
Social Security No. **[MUST BE FILLED IN FOR PATIENT TO BE SEEN]** ___ ___ ___ - ___ ___ - ___ ___ ___ ___		Date of Birth	

I certify that I, and/or my dependent, have insurance coverage as noted on page 2 of this Patient Registration Form, and I assign directly to Morristown Oral Surgery & Implantology Associates all benefits for all services rendered should I have insurance with Aetna Dental PPO and DMO, Ameritas Dental PPO, Cigna Dental PPO & Advantage, Delta Dental PPO, Dentemax, Guardian DentalGuard PPO, Healthplex PPO/4A,28A,31A,32A,4G, Horizon Dental Traditional & PPO, Humana Dental PPO, MetLife Dental PPO, Principal Dental PPO, TriCare Dental PPO, United Concordia Dental PPO, and United Healthcare Dental PPO in which Dr. Fang participates, and I authorize my printed "signature(s)" on all insurance submissions. **I agree to follow up with all of my carrier(s) to insure they process my pre-determinations (estimates) and claims within 31 working days. I understand that expediting payment by my carrier(s) to Dr. Fang/Dr. Keiser is my responsibility.**

✦ I understand that **if** Dr. Fang and Dr. Keiser participate with my dental insurance, the estimated copay is due at the time of service. Further, I understand that the credit card on file will be automatically charged or credited for any adjustments after my insurance claim is adjudicated when the final Explanation of Benefits is received by Dr. Fang and Dr. Keiser from a dental insurance carrier noted above. **NOTE:** If a **valid** credit card is not on file with us, **a charge for initial billing and rebilling fees as well as other service charges will apply.** ✦

I certify that I have read and understand the information on pages 1 through 4 of this Patient Registration Form and understand that I am responsible for payment of my account in full. I agree to accept financial responsibility for all fees as per New Jersey law regardless of any insurance coverage I may have; I will be responsible for our FULL FEE *(not an insurance company "negotiated fee")* for treatment which is not covered by my insurance plan in accord with New Jersey Law. Should my carrier(s) deny any treatment, I understand that I am responsible for Dr. Fang's fee.

I hereby agree and promise to pay interest of 1.5% per month on the outstanding balance calculated beginning 30 days from the date of service and $5.00 billing and rebilling fees for every statement sent. In the event that this account needs to be placed with an attorney and/or a collection agency, in addition to the interest previously noted, I also agree and promise to pay a collection fee of $100.00 or 25% of the total balance due, whichever is greater, as well as legal fees upon placement with an attorney or collection agency because of any unpaid balance on my account.

I understand that neither the doctor nor members of his staff makes assurances, inferences, or guarantees regarding payment policies, treatment estimates, or insurance coverage; and no coding changes will be made. **I understand that the conditions stated in this document cannot be modified by the patient and/or guarantor as the information printed herein is the ONLY contract.**

This entire document (pages 1 through 4) is a binding contract.

FINANCIALLY RESPONSIBLE PARTY M U S T SIGN AND DATE BELOW

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY	SIGN HERE	DATE

Consent for Use & Disclosure of Health Information and Notice of Privacy Practices is attached for your review and signature.

Morristown Oral Surgery & Implantology Associates

290 madison avenue, morristown, new jersey 07960 • 973-538-5338

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, insurance, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices (attached) before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting Morristown Oral Surgery & Implantology Associates.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Morristown Oral Surgery & Implantology Associates. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient's Name *(please print)* _____

Signature _____ **Date** _____

Relationship to Patient _____

A MINOR MAY NOT SIGN THIS FORM.

UPON YOUR REQUEST, YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Morristown Oral Surgery & Imlantology Associates

Notice of Privacy Practices Page 1 of 2

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS INFORMATION CAREFULLY

You have the right to get a copy of your paper or electronic medical record, correct your paper or electronic medical record, request confidential communication, ask us to limit the information we share, choose someone to act for you, get a list of those with whom we've shared your information, get a copy of this privacy notice, file a complaint if you believe your privacy rights have been violated.

You have some choices in the way that we use and share information as we tell family and friends about your condition, provide disaster relief, Include you in a hospital directory, provide mental health care, market our services and sell your information, raise funds.

Our Uses and Disclosures - We may use and share your information as we treat you; run our organization; bill for your services; help with public health and safety issues; do research; comply with the law; respond to organ and tissue donation requests; work with a medical examiner or funeral director; address workers' compensation, law enforcement, and other government requests; respond to lawsuits and legal actions.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record, ask us to correct your medical record, ask to see or get an electronic or paper copy of your medical record and other health information we have about you, ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You can request confidential communications, ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. You can ask us to limit what we use or share, ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. You can ask for a paper copy of this notice at any time, and we will provide you with a paper copy promptly. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. You can complain if you feel we have violated your rights by contacting us using the information on page 2. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa /complaints. We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In the following cases we never share your information unless you give us written permission--marketing purposes, sale of your information; most sharing of psychotherapy notes. In the case of fundraising, we may

Morristown Oral Surgery & Imlantology Associates

Notice of Privacy Practices Page 2 of 2

Our Uses and Disclosures - How do we typically use or share your health information? We can use your health information and share it with other professionals who are treating you (example: a doctor treating you for an injury asks another doctor about your overall health condition), to run our practice, improve your care, and contact you when necessary (example: we use health information about you to manage your treatment and services), to bill and get payment from health plans or other entities (example: we give information about you to your health insurance plan so it will pay for your services). We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety; for health research; if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with federal privacy law; organ procurement organizations; a coroner, medical examiner, or funeral director when an individual dies; workers' compensation claims; law enforcement purposes or with a law enforcement officials; health oversight agencies for activities authorized by law; special government functions such as military, national security, and presidential protective services; in response to a subpoena, court, or administrative order.

We are required by law to maintain the privacy and security of your protected health information; we will let you know if a breach occurs that may have compromised the privacy or security of your information; we must follow the duties and privacy practices described in this notice and give you a copy of it; we will not use or share your information other than as described here unless you tell us we can in writing (if you tell us we can, you may change your mind at any time--let us know in writing if you change your mind). For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/ consumers/noticepp.html.

Regarding Morristown Oral Surgery & Implantology Associates' Notice of Privacy contact Morristown Oral Surgery & Implantology Associates, 290 Madison Avenue, Morristown, NJ 07960, telephone 973-538-5338, email morristownoral@optimum.net. The effective date of this Notice is August 1, 2018. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office