Heritage Lake Dental
Catherine M. Wong, D.D.S. John Smolnicky, D.D.S.

DATE:_____S.S.N._____D.O.B._____PATIENT NAME:_____

PARENT NAME(if pt is a minor):_____ADDRESS:_____

CITY:_____ST:_____ZIP:_____HOME#_____CELL#:_____

WORK#:_____EMAIL ADDRESS:_____

BEST WAY TO CONTACT YOU:_____REFERRED BY:_____

PATIENT/PARENTS EMPLOYER:_____POSITION:_____

INSURANCE CO.:_____SUBSCRIBER SSN:_____SUBSCRIBER DOB:_____

I, _____, give my permission to have my photograph or video used for the purpose of marketing for the dental office. I understand that my name will not be used, and will not be sold for any other office use. I also understand that I will not be compensated for the use of my photograph(s) unless otherwise discussed.

ACCEPT ☐ DENY ☐

IF YOU ARE COVERED BY A DENTAL INSURANCE, IT IS IMPORTANT THAT **YOU** ARE AWARE OF THE EXTENT OF YOUR COVERAGE. **MOST INSURANCE COMPANIES OFFER BENEFITS FOR ONLY A PORTION OF THE TOTAL SERVICES YOU RECEIVE.** IT WILL BE NECESSARY FOR YOU TO MAKE PROPER ARRANGEMENTS TO HANDLE THE PATIENT PORTION OF YOUR CHARGES UP FRONT. THE FEES WE CHARGE FOR SERVICES RENDERED TO THOSE WHO ARE INSURED IS OUR USUAL AND CUSTOMARY FEES CHARGED TO ALL PATIENTS FOR SIMILAR SERVICES UNLESS WE ARE IN NETWORK. YOUR POLICY MAY BASE ITS ALLOWANCE ON A FIXED FEE SCHEDULE WHICH MAY OR MAY NOT COINCIDE WITH OUR FEES. WE URGE YOU TO BE FULLY INFORMED OF THE BENEFITS AVAILABLE TO YOU THROUGH YOUR INSURANCE. WE WILL ASSIST YOU IN PREPARING YOUR INSURANCE CLAIM, HOWEVER **WE ASK THAT YOU PAY YOUR ESTIMATED PORTION AT THE TIME OF TREATMENT**. THIS OFFICE IS NOT RESPONSIBLE FOR YOUR INSURANCE COMPANIES DELAY IN PAYMENT, OR FOR YOUR COMPANIES DETERMINATION AS TO HOW MUCH OF THE FEES THEY WILL PAY. ALL CHARGES NOT PAID BY INSURANCE ARE DUE WITHIN 30 DAYS OF NOTIFICATION UPON NON PAYMENT.

PLEASE BE PROMPT FOR YOUR APPOINTMENTS. IF YOU ARE LATE, IT REDUCES THE TIME THAT WE HAVE TO SPEND WITH YOU. A BROKEN APPOINTMENT FEE WILL BE CHARGED AT A FEE OF $65 PER HOUR FOR ANY APPOINTMENTS CANCELLED, MISSED, OR RESCHEDULED LESS THAN 48 HOURS BEFORE SET APPOINTMENT TIME.

- I, THE PATIENT, AND/OR RESPONSIBLE PARTY WILL PAY FOR SERVICES RENDERED BY WONG & SMOLNICKY, P.C. WHEN TREATMENT IS RENDERED.
- I, THE PATIENT, AND/OR RESPONSIBLE PARTY WILL PAY ANY BALANCE WITHIN 45 DAYS FROM THE DATE OF SERVICE RENDERED.
- I AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT TO WONG & SMOLNICKY, P.C.
- I AUTHORIZE WONG & SMOLNICKY, P.C. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF EXAM AND/OR TREATMENT TO MY INSURANCE COMPANY.
- I AGREE THAT UPON DEFAULT IN PAYMENT, I JOINTLY AND SEVERELY WILL BE LIABLE FOR THE SERVICES RENDERED AND INTEREST AT 18% ALONG WITH REASONABLE ATTORNEY OR COLLECTION AGENCY FEES IN THE COLLECTION THERE ON.
- I AGREE TO PAY WONG & SMOLNICKY, P.C. A RETURNED CHECK FEE OF $50.00 FOR ANY RETURNED CHECKS.

SO AGREED,

PATIENT SIGNATURE:_____DATE:_____

RESPONSIBLE PARTY (IF MINOR OR INSURANCE SUBSCRIBER):_____DATE:_____