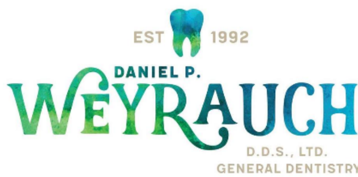


PATIENT INFORMATION

FIRST NAME:________________________LAST NAME:_______________________PREFERRED NAME: _______________________ MIDDLE INITIAL:___________

BIRTH DATE: ____ SS #:_______________________________________ SEX: [ ] Male [ ] Female [ ] Non-Binary

ADDRESS:____

CITY / STATE / ZIP:____MARITAL STATUS: ___________________

HOME #:____ WORK #:___________________________________ CELL #:___________________________

EMAIL:____

EMPLOYER:____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

FIRST NAME:____ LAST NAME:_________________________________ MIDDLE INITIAL:_____________________

BIRTH DATE:____ SS #:_______________________________________ SEX: [ ] Male [ ] Female [ ] Non-Binary

ADDRESS:____

CITY / STATE / ZIP:____

HOME #:____ WORK #:___________________________________ CELL #:___________________________

EMAIL:____

EMPLOYER:____

DENTAL HISTORY

PREVIOUS DDS:____LAST VISIT DATE:______________________________

REFERRAL INFORMATION

WHOM MAY WE THANK FOR YOU REFERRING YOU? ____

EMERGENCY CONTACT

NAME:____ Phone Number ____

INSURANCE INFORMATION

INSURANCE COMPANY:____ INSURED NAME:____

INSURED DOB:____ INSURED SS#:____

GROUP NAME:____GROUP #:___________________________________ ID #:______________________________

INSURED EMPLOYER:____

CONSENT

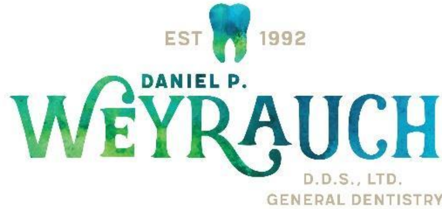
I understand that the information that I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance may not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

I have read and understand the above policies and agree to abide by the listed terms. This agreement remains in effect until the listed expiration date and/or when an updated policy is implemented.

Expiration Date (circle one): none one year

SIGNATURE: ____**DATE:** ____________________________________



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

____
____
____

INSURANCE AGREEMENT

I understand that my insurance will only pay a portion of my treatment (according to their plans and provisions). I am responsible for any balance(s) not paid by my insurance company.

I understand that Dr. Daniel P. Weyrauch will file the claim with my insurance company. If there are any denials and/or benefits are not paid, it is my responsibility to call the insurance company and discuss any issues with them.

I understand that if I receive any benefit payment from the insurance company I am responsible for any outstanding balance I have with Daniel P. Weyrauch. After which, I will make payment in full at time of service and have the insurance company reimburse me for all other treatment.

I understand that Dr. Daniel P. Weyrauch is not responsible for submitting any outstanding claims and/or collecting any benefit payment(s) owed by the insurance company after forty-five (45) days from the first claim submission and/or date of service.

FINANCIAL RESPONSIBILITY

The undersigned hereby states that he/she is the patient and/or financially responsible party and is personally liable for and/or personally guarantees all amounts due to Dr. Daniel P. Weyrauch, including service charges. This obligation and/or personal guarantee shall remain in force and effective as long as there is any amount due for professional services extended to the patient and/or financially responsible party.

The undersigned agrees and guarantees that, in the event of default in payments when due, that he/she will pay, in addition to all sums due, all costs of collection, including attorney's fees and courts costs and all collection agency fees, not to exceed 30%, incurred by Dr. Daniel P. Weyrauch.

The undersigned agrees to pay a service charge of 1 ½ % per month or 18% annually for all invoices or statements of account not paid within 90 days.

____

Please Print Name

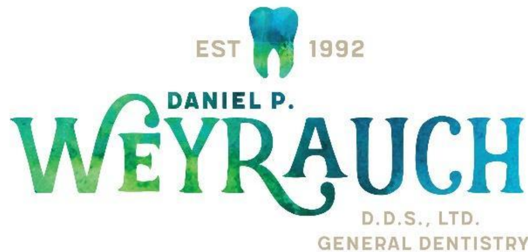
____

Signature

Date

I have read and understand the above policies and agree to abide by the listed terms. This agreement remains in effect until the listed expiration date and/or when an updated policy is implemented.

Expiration Date (circle one): none one year



CANCELLATION AND BROKEN APPOINTMENT POLICY

With the increase of cancellations and broken appointments we have found it necessary to implement the below policy effective 09.01.22:

- **CONFIRMING YOUR APPOINTMENT**: Our patient communication program will notify you via email and/or text 14 days, 7 days, 2 days and 2 hours prior to your scheduled appointment. Failure to confirm within 48 hours of your scheduled appointment will forfeit your appointment. Please also remember, it is your responsibility to make sure we have your current phone / email on file.
- **LESS THAN 48-HOUR CANCELLATION:** We ask that you give us a minimum of 48-hour advanced notice for cancellations or to reschedule your appointment. Please note, all Monday appointments need to be changed by 12:00pm on Thursday or a cancellation fee will apply. Canceling the "day of" your scheduled appointment will be considered a broken appointment. The cancellation and broken appointment fees are the sole responsibility of the patient and must be paid in full before another appointment can be made.
- **NUMEROUS BROKEN APPOINTMENTS:** Patients who do not show for their reserved appointments will be considered as "broken appointments". Patients who have repeated "broken appointments" on their account will be required to prepay for all dental appointments prior to scheduling.
- **ARRIVE ON-TIME**: We strive to be on time for your appointment and ask that you give us the same courtesy. If you arrive late for your appointment, we reserve the right reschedule and this will be considered a "broken appointment". We ask all patients to arrive 10 minutes prior to their schedule appointments.
- **BROKEN APPOINTMENT FEE:** A fee of $45.00 (minimum) will be applied to your account for any broken appointments. Appointments over one hour will be assessed a prorated fee up to $100.00 per appointment. No additional appointment may be made until this fee is paid.

Questions regarding this policy should be directed to our Clinic Administrator.

I have read and understand the above policies and agree to abide by the listed terms. This agreement remains in effect until the listed expiration date and/or when an updated policy is implemented.

Expiration Date (circle one): none one year

____

Patient / Guardian Signature

____

Date

1075 Featherstone Road Suite 40 | ROCKFORD IL, 61107 | (815) 399-4379

WRITTEN FINANCIAL POLICY

Thank you for choosing DANIEL P WEYRAUCH DDS LTD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

Cash/Check Visa® MasterCard® Discover Card® Care Credit®

For plans requiring multiple appointments, alternative payment arrangements may be provided.

INSURANCE:

We are happy to work with your insurance to help maximize your benefit and directly bill them for reimbursement for your treatment. Ultimately, it is your responsibility to know your individual dental benefits and any restrictions that may apply. If we do not receive payment from your insurance within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance provider.

DOWN PAYMENT:

For larger, more comprehensive treatment plans of $500 or more, a $150.00 deposit is required to secure your initial treatment appointment.

ADDITIONAL FEES:

- $45.00 (minimum) fee for missed or canceled appointments without a 24-hour notice
- $35.00 (minimum) fee for returned checks
- If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I have read and understand the above policies and agree to abide by the listed terms. This agreement remains in effect until the listed expiration date and/or when an updated policy is implemented.

Expiration Date (circle one): none one year

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Patient, Parent or Guardian Signature Date

Patient Name (Please Print)