
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.

Please Print Name

Signature

Date

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

REGISTRATION AND HEALTH HISTORY

Rossetti & Myers, DDS

Name		Single	Married	Divorced	Separated	Widowed
Social Security number		Birthdate		E-mail address		
Home Phone		Cell Phone		Business Phone		
Residence address			City	State	Zip	
Employed by			City	State	Zip	
Present position		How long held		Your driver license no.		State
Spouse Name						
Spouse's Social Security number		Spouse birthdate		Business phone		
Spouse employed by			City	State	Zip	
Present position		How long held		Spouse driver license no.		State
Referred by		Address				
Who will pay for this account?		Credit card name		No.	Expiration date	
Name of your dental insurance company						
Group no.			Policy no.			
Name of your spouse's dental insurance company						
Group no.			Policy no.			

MEDICAL HISTORY

Physician's name _____ Date of last physical exam _____

Do you have or have you had any of the following. Please indicate with check mark (✓).

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergies to medicines or drugs | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Allergies to _____ | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Radiation treatments | <input type="checkbox"/> Asthma | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS | | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other |

Are you pregnant _____ Blood Pressure: S ____/D ____/____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. List all current medications.

Date: _____

Signature: _____

Date: _____

Changes in medical history and medications:

Patients signature

Date: _____

Changes in medical history and medications:

Patients signature

Date: _____

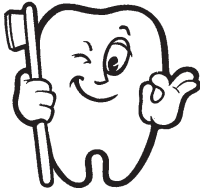
Changes in medical history and medications:

Patients signature

Date: _____

Changes in medical history and medications:

Patients signature



**MICHAEL A. ROSSETTI, D.D.S., MAGD
CLAIRE MYERS, D.D.S.**

**2613 PARHAM ROAD • RICHMOND, VIRGINIA 23294
(804) 747-0090 • FAX (804) 270-9461 • WWW.ROSSETTI-MYERS.COM**

Assignment of Benefits and Payment Agreement and Authorization to Release Information

I hereby authorize Rossetti & Myers, D.D.S., to furnish to my insurance carrier(s), attorney, or legal representative all information which said parties may request concerning my treatment. I hereby assign to Rossetti & Myers, D.D.S., until the amounts owed including interest and attorney fees are paid in full. I further agree and accept as follows:

That my insurance policy is a contract between my insurance carrier and me. I recognize that I am personally responsible to Rossetti & Myers, D.D.S. for ALL charges for services rendered plus interest that will accrue on the outstanding balance at the rate of 1½% per month (18% annum).

I recognize that Rossetti & Myers, D.D.S. will bill and collect from my insurance carrier as a courtesy to me. I will be informed as to any balance due from me to Rossetti & Myers, D.D.S. I fully understand that Rossetti & Myers, D.D.S. may not accept the amount as the insurance carrier states as their "usual & customary fees" (UCR) as payment in full. This may lead to a bill for deductibles, co-payments, and co-insurance. Regardless of my insurance, I may have a balance due for services rendered. I agree to pay for any such balance. For those policies that require pre-authorization or referrals, this must be completed prior to seeing any dentist. I am responsible for understanding my individual insurance policy and benefits prior to seeking services. I will ask for help if my insurance is not clear to me.

Although I may be represented by an attorney on matters related to the treatment which Rossetti & Myers, D.D.S. has rendered to me, I must still keep my account paid in full.

If my account becomes delinquent and is referred to an attorney or agency for collection, I agree to pay a minimum of 30% attorney fees, all court costs incurred by Rossetti & Myers, D.D.S. in addition to the outstanding balance of the account.

I fully understand that while Rossetti & Myers, D.D.S. is willing to send an insurance claim to my insurance carrier, this is done as a courtesy, and Rossetti & Myers, D.D.S. will not be responsible for lost claims or claims that do not arrive at my insurance carrier. Patients are encouraged to remain in touch with their insurance carrier to determine the status of the claim. I understand that if payment from my insurance carrier is not received by Rossetti & Myers, D.D.S. within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collections.

This agreement is in addition to any other agreement which I may have with Rossetti & Myers, D.D.S. I have read this document, understand it fully, and agree to the terms and conditions.

Signature _____ Date _____

OUR FINANCIAL POLICY

Thank you for choosing Rossetti & Myers, D.D.S. as your dental care provider. The following is a statement of our Financial Policy which we ask you to read and sign prior to any treatment. All patients must complete this information before seeing the dentist.

PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS and CREDIT CARDS (VISA & MASTERCARD).

Insurance

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original insurance card at each visit to copy and keep on file. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may not be covered. You will be responsible for these balances. (Initial _____)

Adult and Minor Patients

Adult patients are responsible for full payment at time of service. The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard (which may be kept on file), or payment by cash or check at time of service has been verified. (Initial _____)

Returned Checks

There will be a \$30 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we will call your bank to verify funds for any future checks that are presented for payment on your account. (Initial _____)

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees. (Initial _____)

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for a missed appointment at the rate of no less than \$100 per missed appointment. Please help us to serve you better by keeping scheduled appointments. (Initial _____)

Fees for Letters and Forms

Your Dentist will be more than happy to fill out any necessary forms that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by the insurance companies. The fee for this service is \$20.00. (Initial _____)

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

x _____ Date _____
Signature of Patient or Responsible Party

x _____ Date _____
Signature of Co-Responsible Party