

Patient Name:  
Patient DOB:  
Date:

## Patient, Pharmacy and Insurance Information

Patient Prefix: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male  Female  Unspecified

Preferred Phone#: \_\_\_\_\_ Is this a **mobile** number? Yes  No

I consent to receive SMS/text messages from **Keystone Oral Surgery and Implant Center** for appointment reminders, billing notifications, and follow-ups. Message and data rates may apply. Message frequency may vary.

Email Address: \_\_\_\_\_ May we email you to communicate: Yes  No

Preferred Billing Correspondence Method:  Text Message  Email  Paper Mail

Emergency Contact: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

Purpose of the visit: Emergency  Extraction  Implant  Other

Do you need Translation services: Yes  No  (We use Cyrocom Services for Translation Services)

Would you like to use family/Friend for translation: Yes  No

## Preferred Pharmacy

**Note: When a prescription for narcotic pain medication is sent to a pharmacy, it generally cannot be canceled or transferred to another pharmacy.**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Responsible Party:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_ Sex: Male  Female

Unspecified

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental Insurances (Primary)

Is the Subscriber same as the Patient: Yes  No

### Subscriber Information:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Ins Ph#: \_\_\_\_\_

Subscriber ID/Policy Number: \_\_\_\_\_ Group/Contract Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Relationship to Subscriber:  Child  Disabled Dependent  Spouse  Self  Other Dependent

Subscriber SSN: \_\_\_\_\_

## Secondary Insurance (If applicable)

Is the Subscriber same as the Patient: Yes  No

### Subscriber Information:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Ins

Ph#: \_\_\_\_\_

Subscriber ID/Policy Number: \_\_\_\_\_ Group/Contract Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Relationship to Subscriber:  Child  Disabled Dependent  Spouse  Self  Other Dependent

Subscriber SSN: \_\_\_\_\_

**By signing below, I acknowledge that I have read, understand, and agree to the information provided above**

Patient Name:  
Patient DOB:  
Date:

Patient/Guardian signature \_\_\_\_\_

Date: \_\_\_\_\_

### NOTICE AND CONSENT TO VIDEO RECORDING

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable Pennsylvania law, I understand and consent that video recording may occur within Keystone Oral Surgery & Implant Center for patient safety, security, quality assurance, training, and operational review.

Video recording may occur in both clinical and non-clinical areas, including but not limited to hallways, consultation areas, operating rooms, recovery rooms, and treatment areas, as permitted by law.

I acknowledge that video recordings may incidentally capture Protected Health Information (PHI) and are maintained, accessed, used, and disclosed in compliance with HIPAA, the clinic's Notice of Privacy Practices, and applicable Pennsylvania law. Recordings are used solely for authorized internal purposes or as otherwise permitted or required by law.

I have read, understand, and consent to video recording as described above.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor, I certify that I am the parent or legal guardian and have legal authority to consent on the minor's behalf.

Minor Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. (Privacy Policies are provided).

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Name (Print): \_\_\_\_\_ Patient Signature : \_\_\_\_\_ Date: \_\_\_\_\_

#### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

The patient refused to sign.

Other \_\_\_\_\_

Patient Name:  
Patient DOB:  
Date:

Employee signature \_\_\_\_\_

Date: \_\_\_\_\_

## Agreement of Financial Responsibility

Thank you for choosing Keystone Oral Surgery Associates. Please review and acknowledge the following financial policy prior to treatment.

Payment is due at the time services are rendered. We accept cash, check, credit cards, and applicable insurance for contracted providers. Patients are responsible for understanding their insurance coverage, including network status, benefits, exclusions, pre-authorization requirements, and out-of-pocket costs. Certain procedures and diagnostics (including CBCT scans, surgical procedures, and biopsies) may not be covered.

We will attempt to verify insurance coverage; however, it is your responsibility to provide current and accurate insurance information. Failure to do so may result in full financial responsibility.

For contracted insurance plans, we will bill your insurance after collecting applicable copayments and deductibles. Any remaining balance will be billed to you after insurance processing (typically 45–60 days). If we are out-of-network, full payment is due at the time of service, and a receipt will be provided for possible reimbursement.

Photo ID and proof of payment are required. Copies of your ID and insurance card will be kept on file. Insurance verification does not guarantee coverage or payment. Out-of-network benefits may result in higher patient responsibility.

By signing below, you acknowledge understanding and acceptance of this financial responsibility, including responsibility for all charges not covered or denied by insurance.

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Patient /Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Patient /Responsible Party(Please Print): \_\_\_\_\_ Relationship: \_\_\_\_\_

## General Anesthesia Financial Responsibility Agreement

Patient Name: \_\_\_\_\_

**Patient Name:**  
**Patient DOB:**  
**Date:**

I understand that my dental insurance plan may not cover the full cost of general anesthesia. A claim will be submitted along with all relevant sedation records. If the insurance provider denies coverage for general anesthesia, I agree to be financially responsible for the cost incurred. The current rate for general anesthesia is \$175.00 per 15-minute interval.

Patient Name (Print): \_\_\_\_\_ Patient Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CBCT Scan Financial Responsibility Agreement

I understand that a Cone Beam Computed Tomography (CBCT) scan may be necessary for diagnosis and treatment planning. While a claim will be submitted to my insurance provider, I acknowledge that coverage for the CBCT scan is not guaranteed. If the insurance denies the claim, I agree to be responsible for the full cost of the CBCT scan.

Patient Name (Print): \_\_\_\_\_ Patient Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Cancellation and Rescheduling Policy

This policy is designed to respect both the clinic's time and other patients' needs. We appreciate your understanding and cooperation. **To ensure efficient service for all our patients, please adhere to the following policy:**

- 1. IV Sedation Appointments:**
  - A 72-hour advance notice is required for cancellation or rescheduling.
  - A fee of \$150 per 30 minutes of scheduled appointment time will be charged for late cancellations or no-shows.
- 2. Rescheduling After a No-Show:** Appointments can be rescheduled after a 2-week waiting period.
  - A \$150 fee must be paid at the time of rescheduling.
  - The doctor will see you on the rescheduled date if time permits.
- 3. Pre-Sedation Instructions:** (All necessary forms and instructions will be provided during your consultation)
  - Failure to follow pre-sedation instructions will result in rescheduling.
  - A fee of \$150 per 30 minutes of the original appointment time will apply.

We understand that emergencies may arise. Please contact our office immediately if you need to cancel or reschedule. Adherence to this policy helps us provide timely care to all our patients.

By signing below, I acknowledge that I have read, understand, and agree to this cancellation and rescheduling policy.

**Patient Name (Print):** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_