WELCOME TO OUR OFFICE

We at Beck Dental Center, P.C. take great pleasure in welcoming you as a NEW PATIENT. We will do our utmost to make our association a mutually pleasurable experience. We pride ourselves in providing all of our patient's with the very best dental care possible. As such, following are our normal business policies:

INSURANCE: We accept assignment of benefits for MOST insurance plans. However, estimated co-pays, deductibles and/or out of pocket expenses are due and payable at the time services are rendered. If there are more than two insurance carriers involved the patient is responsible for filing any subsequent claims.

As a courtesy we will gladly file your insurance claim[s] and will do our very best to facilitate payment by your insurance carrier. Generally, we allow 60 days for the insurance carrier to pay a claim. In most cases this is sufficient time for a claim to be paid. However, after 60 days the guarantor is responsible for any outstanding account charges.

It is your responsibility to determine if we are a provider on your particular insurance plan, and knowing your dental benefits, including contract frequencies and limitations on services performed.

FINANCIAL ARRANGEMENTS: We have several payment options available to our patients. They allow patients to receive their desired dental care and still remain within their budget:

We accept **ALL MAJOR CREDIT CARDS, CASH, PERSONALCHECKS, DEBIT CARDS and CARE CREDIT [*an INTEREST FREE FINANCE PLAN-*subject to individual approval**)**. Also available is an extended payment plan for up to 60 months with a low interest rate. (**Please ask for details or see the included brochure.**)

We apply a 1-1/2% monthly finance charge (APR 18%) for any charges not paid in full after 60 days.

We offer a **5% discount** when **treatment charges** total over **$1000**; and a **10% discount** if treatment is over **$2500**, The total treatment **must be paid in full with cash or Cashier's Check prior to the start of treatment.** We will file the insurance claim and direct the payment to the insured. In the event the insurance payment comes to the office, a speedy refund will be forwarded to the quarantor. **We DO NOT accept assignment of benefits with these discounts.**

WARRANTY: We warranty all services performed as listed in the provided warranty brochure. Please review for details. You signature below acknowledges receipt of a copy of our warranty brochure.

BUSINESS HOURS:					
MONDAY	**9:00 am to 7:00 pm**	**TUESDAY**	**9:00 am to 7:00 pm**
WEDNESDAY	**9:00 am to 5:00 pm**	**THURSDAY**	**9:00 am to 4:00 pm**
FRIDAY	**CLOSED**	**SATURDAY**	**CLOSED**

WE ARE CLOSED ON MAJOR HOLIDAYS

CANCELLATIONS: We ask that should it become necessary to reschedule or cancel an appointment, please notify our office at least **48 hours prior** in order to allow us the opportunity to offer the reserved appointment time to another patient. We understand that emergencies occur, however, short notice cancellations and NO SHOWS affect all of our patients resulting in time lost and treatment delayed.

When a short notice cancellation or NO SHOW occurs there will be an administrative fee charged for each appointment scheduled in the amount of **$50** for a **weekday** appointment and **$100** for a **Saturday** appointment. **Saturday appointments are premium time and as such so is the administrative fee! When multiple appointments are scheduled on the same day, there is a charge for each appointment scheduled that is missed or cancelled. LATE ARRIVALS** that prevent sufficient time to complete the scheduled procedure(s) will be rescheduled and may be subject to a charge.

We value our patient's time and do everything possible to see each patient at their appointed time. However, please be aware there may be times when emergencies prevent us from seeing a patient at their exact scheduled appointment time. We will give you the option of staying for treatment or offer to reschedule to a more convenient time.

*** THERE IS 24 HOUR VOICE-MAIL AVAILABLE AT ALL TIMES – PLEASE LEAVE A MESSAGE WE WILL RETURN YOUR CALL ***

We at Beck Dental Center, P.C. wish to thank you for the opportunity to provide your dental care and look forward to a long and mutually pleasant association.

Our knowledgeable staff is always available to answer any questions you may have, **please do not hesitate to ask**.

Thank you,
Richard L. Beck, D.D.S.

I have read & acknowledge receipt of a copy of this document and the warranty brochure.

Signature of Patient, Responsible Party or Guarantor _____ Date _____

Beck Dental Center, P.C. 233 E. 84th Drive, Suite 106 Merrillville, Indiana 46410
e-mail address: beckdentalcenter@gmail.com
Phone: 219-736-2309 Fax: 219-736-2328

PATIENT REGISTRATION

Please Print

Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Social Security No: _____ Drivers Lic: _____

Sex: _____Male _____ Female Marital Status: _____Married _____Single _____Divorced _____Separated _____ Widowed

Employer: _____ Student Status: _____Full Time _____Part Time

Employment Status: _____ Full Time _____ Part Time _____ Retired Name of School: _____

Responsible Party (if other than Patient): Relationship to Patient: _____ Self _____ Spouse _____ Child _____ Guardian

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Soc. Sec. #: _____ Drivers Lic: _____

Sex: _____ Male _____ Female Marital Status: _____ Married _____ Single _____ Divorced _____ Separated _____ Widowed

Employment Status: _____ Full Time _____ Part Time _____ Retired Student Status: _____ Full Time _____ Part Time
Name of School: _____

Insurance Information: **Primary Carrier:** Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Guardian

Insured Name: _____ Birth Date: _____

Insured ID # or Soc. Sec. #_____ Group No: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City _____ City: _____

State/Zip: _____ Phone: _____ State/Zip: _____ Phone: _____

Secondary Carrier (if applicable): Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Guardian

Insured Name: _____ Birth Date: _____

Insured ID # or Soc. Sec. #: _____ Group No: _____

Employer: _____ Insurance Co: _____

Address: _____ Address: _____

City: _____ City: _____

State/Zip: _____ Phone: _____ State/Zip: _____ Phone: _____

In Case of Emergency Please Contact:

Name: _____ Phone: _____ Relationship to Patient: _____

Preferences: **Preferred Name:** _____

Preferred Pharmacy: _____ Phone: _____

Address: _____ City, State, Zip: _____

E-mail: _____ I would like to receive notification via e-mail: ____Yes ____ No

BECK
Dental Center

TO ALL OF OUR PATIENTS WITH INSURANCE:

Occasionally, there is some confusion about how insurance carriers process and pay dental claims. We would like to clarify some of this confusion:

We deal with many insurance companies and have several thousand patients. We accept most insurance companies and are a participating provider [PPO] on many. **We will verify coverage and benefits prior to your initial visit only to our office and/or if your carrier changes.**

We do not check your benefits or coverage prior to every visit to the office! This is up to you.

Changes occur to your insurance coverage all the time. Insurance companies do not notify us of these changes. We can only rely on our patients to inform us if there are any changes in the coverage or the insurance company.

As a courtesy we complete your claim for payment and expect you as the recipient of services to pay any co-pays and/or deductibles at the time service[s] are performed. **The amount due is an estimate only**! It is based upon information received from your insurance carrier when we initially verify your benefits. **We are unable to guarantee the amount(s) quoted at the time of service to be exact**! Your insurance carrier determines this based on the contract agreement chosen by your employer.

All charges incurred are billed to your insurance carrier at our normal or standard fee whether or not they are a covered benefit on your policy. Submitting non-covered services establishes a history of use; over time this may encourage insurance carriers to cover these services.

For PPO Plans: A contractual adjustment is made to our standard fee based on your PPO. Occasionally, there may be times this adjustment is different from what we have on file due how your insurance carrier processes your claim. These adjustments and/or corrections will appear on your statement. You as the insured are responsible for any amounts not paid by the insurance plan up to the contracted PPO fee.

For All Insurance Plans: When a service is not covered or denied by your insurance carrier, you, as the insured are responsible for the remaining account balance, knowing what your insurance coverage is, along with its frequencies or limitations on services performed.

Please contact your insurance carrier or employer and request a plan coverage book to review your benefits. Most carriers have a web site with basic benefits listed. **Please be a knowledgeable consumer!**

We try our very best to be as accurate as possible. We will make every effort to correct and/or rectify any and all inaccuracies to the satisfaction of both parties. Please review all statements and call the office immediately if you have any questions or concerns.

I have read and acknowledge receipt of a copy of this document.

_____ Date: _____

Guarantor or Insured signature

Thank you
Beck Dental Center PC
Richard L. Beck, D.D.S.

TO OUR PATIENTS WITH INSURANCE:

Please be advised, we will gladly submit your dental claims for payment and request that you pay your estimated portion at the time services are rendered.

ALSO, PLEASE BE AWARE:

YOU ARE RESPONSIBLE FOR KNOWING WHAT YOUR INSURANCE BENEFITS ARE AND ADVISING THE OFFICE OF ANY CHANGES IN YOUR COVERAGE.

The office will NOT be responsible for denied or non-covered services performed.

Thank You,

Beck Dental Center, P.C.

DENTAL TREATMENT CONSENT FORM

I, the undersigned, understand that I may have or am having any or a combination of the following services: examination; radiographs (x-rays); professional dental prophylaxis (routine preventative cleaning); periodontal treatment (gum disease treatment); endodontic treatment (root canal); fillings; crown restorations; prosthodontics (bridges, dentures or partials); injectible anesthesia; and/or analgesia (nitrous oxide or laughing gas).

I, do hereby authorize Beck Dental Center, P.C., to provide indicated treatment as deemed necessary to provide full and adequate treatment for which I will be given or have been given a full explanation prior to start of treatment. I further understand that I have a full expectation to receive the accepted standard of care for the condition for which I present.

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and or anaphylactic shock (severe allergic reaction).

I fully understand that during the treatment process it may become necessary to change or add procedures because of conditions found while treating the tooth or teeth that were not discovered during examination process. The most common being root canal therapy following routine restorative procedure(s). I give my permission to the treating doctor or designated staff member to make any or all changes and additions as deemed necessary to complete said treatment. I acknowledge that any changes made may affect the final cost of said treatment and I will be given the opportunity to discuss said changes prior to start of procedure.

I understand that it is sometimes not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crown(s) are delivered. I understand and agree that the final opportunity to make any changes in my new crown(s) (cap), or bridge; including shape, fit, size and color will be prior to final cementation (delivery). I further understand that any charges related to my requested changes made after the final delivery will be my responsibility.

I realize that full or partial dentures are artificial and constructed of plastic and/or metal. The problems associated with the wearing of these appliances include, but are not limited to the following: looseness, soreness and possible breakage. I understand and agree that the final opportunity to make any changes in my new appliance; including shape, fit, size, placement and color will be at the final try-in (wax try-in "teeth set in wax") visit. I understand that most immediate placement dentures and/or partials will require a final reline approximately three to twelve months after the initial placement of the appliance. The cost for this procedure is not included in the initial denture/partial charge. I acknowledge that any charges incurred as a result of any changes requested by me after the final completion of the appliance will be my responsibility.

I understand there is no guarantee that root canal therapy will save a tooth, that occasional complications may occur from the treatment, and that occasionally metal objects are cemented in the tooth and/or extend through the root. This does not necessarily affect the success of the treatment. I further understand that occasionally additional surgical procedures may become necessary following root canal treatment, i.e., apicoectomy. I further understand that should a root canal become necessary on a tooth already crowned (capped) there is the possibility the existing crown may fracture resulting in the need for the crown to be replaced. I acknowledge that should this occur I am responsible for the cost of the replacement should my insurance carrier, where applicable, deny coverage for the replacement.

I understand there are alternatives to the extraction (removal) of teeth, i.e., root canal, periodontal surgery, implants, crowns, etc. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

I understand that periodontal (gum) disease is a serious condition causing gum and bone infections, bone loss and can lead to loss of teeth if left untreated. I understand my refusal of treatment will have an adverse affect on my periodontal condition. Alternative treatments, such a gum surgery and or extractions have been offered and explained.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment I have requested and authorized for myself or my minor child or children, where applicable.

I have had or have been given full opportunity to discuss and ask questions regarding any recommended and/or proposed dental treatment; and that any and all my questions have been answered fully to my satisfaction prior to the start of any and all said dental treatment. I further understand that I have the right of refusal of any and all recommended and or proposed dental treatment.

Printed Patient Name _____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative _____ Relationship to Patient _____