Richard S. Shapiro, D.D.S.
www.tgsendo.com

The Medical Quarters
5555 Peachtree Dunwoody Rd., Suite 275
Sandy Springs, GA 30342
404-256-4772 Phone

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fees charged. When endodontic treatment is complete, your tooth will require, for its protection, a permanent restoration or crown. That service is provided by your general dentist and is not included in our fee.

We appreciate your trust in us.

Last Name | First Name | Middle Name

Home Address

City | State | Zip

Home Phone | Work Phone

Cell Phone | Social Security #

Birth Date | E-mail Address

Name of General Dentist

Who should we thank for this referral?

Name of Person responsible for this account

My payment will be made by: ◯ Cash ◯ Check ◯ Credit Card (American Express, Visa, MasterCard or Discover)

Do you have Dental Insurance? ◯ Yes ◯ No

Subscriber's Name | Relationship

Insurance Co. | Phone #

Insurance Address

Employer Name

Subscriber's Birth Date | Social Security #

Group No. | Insurance ID #

OUR PAYMENT POLICY

PAYMENT IS DUE AS SERVICES ARE RENDERED. We are a fee for service practice. As a courtesy, we will gladly file your **PRIMARY** insurance for any procedure rendered and your insurance may reimburse you. A service charge of 1.5% per month (18% annually) will be automatically added to all delinquent accounts past 30 days, from the date of service. All returned checks will incur a $50.00 accounting fee charge. If it becomes necessary to refer your account to a collection agency / attorney, then you will be responsible for any additional cost / fees incurred in the process of collecting your outstanding balance.

OUR INSURANCE POLICY

Prior to your appointment day, we ask that you provide, to us, detailed insurance information. This will allow us to promptly and accurately file your claim, for you, on the day of your appointment. Our goal is to expedite and maximize your reimbursement. Also, please bring your insurance ID card to your appointment.

Payment is due in full, upon completion of your treatment, regardless of your insurance coverage.

Date: | Signature

HEALTH QUESTIONNAIRE

DENTAL CARE IS PART OF YOUR OVERALL HEALTH. IN ORDER THAT WE MAY PROVIDE YOU WITH THE BEST POSSIBLE CARE, PLEASE COMPLETE THIS FORM AS THOROUGHLY AS POSSIBLE.

Have you had any of the following problems or conditions?

Rheumatic Fever ◯ Yes ◯ No

Polio ◯ Yes ◯ No

Jaundice ◯ Yes ◯ No

Heart Problems ◯ Yes ◯ No

If yes, what type

Diabetes ◯ Yes ◯ No

Thyroid Problems ◯ Yes ◯ No

Pregnant now? ◯ Yes ◯ No

Bleeding or Clotting Problems ◯ Yes ◯ No

Nephritis (kidney) ◯ Yes ◯ No

Surgery ◯ Yes ◯ No

If yes, what type

Blood Pressure Problems ◯ Yes ◯ No

If yes, what type

T.B. ◯ Yes ◯ No

Cancer ◯ Yes ◯ No

Sinus ◯ Yes ◯ No

Hepatitis ◯ Yes ◯ No

Epilepsy ◯ Yes ◯ No

Are you HIV positive? ◯ Yes ◯ No

If yes to any of the above, please explain

1. Are you on any daily medications? If yes, please list.

2. Do you have any drug allergies?

3. Are you taking any medication for your current Dental problem?

4. Have you ever had any problems with local Anesthetic?

5. Is there any other information we should have?

Print Name

Date: Signature

PATIENT'S ACKNOWLEDGEMENT OF PAYMENT POLICY & "NO SHOW POLICY"

TGS ENDODONTICS, (a/k/a Tissura, Gregory and Shapiro, PC) specializes in endodontic treatment. We are a fee for service practice. Your clear understanding of our Payment Policy & "No Show Policy" is important to us. Please read carefully. If you have any questions or concerns regarding the Payment Policy or "No Show Policy", please contact our Office at (404)256-4772.

All Patients:

- **I understand that in consideration of the services provided to me, the Patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at TGS Endodontics.**
- If I do not speak English, it is my responsibility to obtain an interpreter to assist in completing and understanding these documents.
- I hereby authorize and assign all payments and/or insurance benefits for dental services and/or surgical procedures rendered to me directly to **TGS Endodontics** unless **TGS Endodontics** agrees otherwise. I hereby authorize **TGS Endodontics** to release any information necessary to process my claim. I understand that I am legally and financially responsible for all charges not covered by my insurance plan.
- I understand you offer nitrous oxide and there is a $85 charge per visit for its use. The use of nitrous oxide is usually not a covered benefit under my insurance plan. I will be responsible for payment of use of nitrous oxide at each visit.
- **It is my responsibility to inform TGS Endodontics of any changes in my contact information.**

Our payment policy is as follows:

All exams are to be paid in full at the time of treatment. If applicable, your insurance will then be filed and requested that it be paid to you.

All other endodontic treatment may be paid as follows:
- You may pay 100% of the total fee at the first appointment or
- You pay 50% of the total fee at the first appointment and the remaining balance upon completion of treatment.

Patients with insurance:

- We gladly file **only** your **PRIMARY** insurance as a **courtesy** to you, our patient. We recommend you review and understand you dental insurance coverage and benefits. Some plans do not cover the treatment of root canals.
- **You need to verify that the information you provide us is accurate and up to date so that we may maximize your insurance benefits in a timely manner. Incorrect information can lead to delayed or even to nonpayment of your claim by your insurance.**
- In order for us to verify your insurance in a timely fashion, we request that, when possible, you submit the needed information to us **AS SOON AS POSSIBLE** prior to your appointment.
- Should you choose to pay the total fee at the start of treatment, insurance will be filed requesting that it be made payable to you.
- Should you choose to pay 50% of the total fee at the start of treatment, then insurance will be filed assigning any payment to **TGS ENDODONTICS**. If we do not receive payment of the balance from your insurance by the appointment for completion, you will need to pay the balance at the appointment. We will then gladly refund you any insurance payment we receive which does not need to be applied to the balance after the completion of your treatment.
- You authorize and assign all payments and/or insurance benefits directly to **TGS Endodontics** for dental services and/or surgical procedures rendered to you by **TGS Endodontics** unless **TGS Endodontics** agrees otherwise. You authorize **TGS Endodontics** to release any information necessary to process your claim. You understand that you are legally and financially responsible for all charges not covered by your insurance plan.
- Some insurance require treatment to be completed prior to filing your claim. In that case, you will need to pay the total fee before we file your claim. We will then request that the claim be paid to you.

Patients with "In Network" Insurance:

- If you are "**In Network**" with one of the insurance companies we are "**In Network**" with, then you will need to inform our office and provide us with your insurance information. Your amount of payment at the start of treatment may be less than 50% depending upon your plan.
- **Timeliness of your submission to us of your insurance information could affect the amount of your payment at the start of treatment.**
- You understand and agree that you are responsible for any **deductibles (in the form of deductible, patient co-pay, office visits, etc.), fees and/or any services not covered by your insurance.** After payment by your insurance company and negotiated adjustments per your insurance company and our office are made, any balance becomes your legal and financial responsibility. If your dental benefit plan does not cover our dental services, then you will be responsible for payment of those non-covered dental services at our regular fees per **OCGA Section 33-24-59.15.**

For other methods of payment:

- Please go to Care Credit at 800-365-8295 or to www.carecredit.com

Payments Past Due and NSF Checks:

- A service charge of 1.5% per month (18% annually) will be automatically added to all delinquent accounts past 30 days, from the date of service. All returned checks (Non Sufficient Fund check) will incur a $50.00 accounting fee charge.

Nonpayment of fees:

- IF you do not pay the total fee at the time the services are rendered, you could be subject to additional fees, costs, and court costs, costs of a collection agency and/or attorney should TGS ENDODONTICS be forced to take such action.

CANCELLATION/NO SHOW POLICY/ RESCHEDULING

- Your appointment is time reserved specifically for you. A broken appointment hurts three people- another patient, you and me.
- **Cancellation or rescheduling without 24 HOUR prior notice to your appointment or failure to show for your scheduled appointment will result in your being charged a $75 fee. "24 Hour Prior Notice" means notifying our office a minimum of 24 hours prior to your appointment.**

I acknowledge that I have read and understand TGS Endodontics' Payment Policy and the Cancellation/No Show Policy/ Rescheduling Policy (a/k/a "No Show Policy").

Patient's Signature: _____ (DATE) _____

If signing as Legal Guardian or Patient's Personal Representative, you will need to provide us with a copy of document(s) which give you that legal authority.

Signature: _____ (DATE) _____

Patient's Legal Guardian or Personal Representative

Printed Name: _____

Relationship to Patient: _____

☐ **I have reviewed this document**

(TGS Rev.12/18/2018)

Secure Submit

HIPAA Compliant

Print Form

“The following links will open documents for review prior to your appointment. This will expedite the registration process. Some of the forms will require your signature at the time of your appointment.”

- HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES
- PATIENT HIPAA OMNIBUS CONSENT FORM
- PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA, PAYMENT POLICY & OMNIBUS CONSENT FORM
- ENDODONTIC CONSENT AND INFORMATION FORM