KEA SMILE STUDIO PLLC

Registration Form

PATIENT

PATIENT LAST NAME	FIRST	MIDDLE	PREFERRED NAME TO BE CALLED	TODAY'S DATE	☐ MALE ☐ FEMALE

BIRTH DATE M. D YR	SOCIAL SECURITY NUMBER	HOME PHONE ☐ NONE MESSAGE PHONE	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP

MAILING ADDRESS	CELL PHONE	CITY	STATE	ZIP CODE

HOME ADDRESS ☐SAME	APT. OR SPACE NO.	CITY	STATE	ZIP CODE

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE ( )	ADDRESS

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	RELATIONSHIP

INSURED INFORMATION (PLEASE FILL OUT COMPLETELY) FINANCIAL RESPONSIBILITY

PERSON RESPONSIBLE LAST NAME	FIRST	MIDDLE	RELATIONSHIP

HOME PHONE ☐SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE

HOME ADDRESS ☐SAME AS ABOVE	CITY	STATE	ZIP CODE

EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION

EMERGENCY CONTACT

LAST NAME	FIRST	MIDDLE	PHONE

HOME ADDRESS	CITY	STATE	ZIP CODE

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐YES ☐NO	SCHOOL ATTENDING	CITY	GRADE

BOTH PARENTS NAMES	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐Fa

PRIMARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE

POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

SECONDARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE

POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

1502 W FLETCHER AVE, SUITE 117 TAMPA, FL 33612 O: 813-968-6100 F: 813-963-1908
WWW.KEASMILE.COM E: OFFICE@KEASMILE.COM

KEA SMILE STUDIO PLLC

Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYBLE AT TIME OFSERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment unless otherwise arranged with management.

Payment Options:

- American Express
- CareCredit
- Cash
- Check
- Discover
- MasterCard
- Visa

Patients with Insurance: The PATIENT is responsible for all payment for procedures and/or deductibles at the time of service. Professional care is provided to you, our patient, not to an insurance company. Thus the insurance company is responsible to the patient and the patient is responsible to the doctor. As a courtesy to you we will assist in every way in filing your claims with your insurance. However, insurance balances 60 days and over are due in full from patient.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check, or credit card authorization form completed.)

Parents accompanying their children are financially responsible for payment at time of service.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$50.00 CHARGE FOR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I realize a responsible adult (Parent or Guardian) must remain in the office while treating a minor.

I, _____, agree to these financial terms.
(Printed Name)

_____ _____
Signature of Patient or Authorized Representative Date

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Our Policy for Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility, we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. You are ultimately responsible for the full amount of all treatment rendered. If your dental insurance pays a portion of your claim, you are responsible for the remaining balance.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

It is important to understand what your dental insurance will cover and the amount you are responsible for to avoid surprises on your dental bill. Your dental coverage is not based on what you need or what is recommended by your dentist.

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

You may be tempted to decide on your dental care based on what your dental insurance plan will pay. Always remember that your health is the most important thing. The least expensive option is not always the best. Insurance companies are not looking out for your best interest and wellbeing. Consider your dental insurance a helping hand in paying some of your dental expenses.

Joita Ghosh, DDS is committed to using the best available materials and dental techniques in dentistry. We will not compromise on the quality of the services we provide despite the innumerous limitations dental insurance companies continue to place on us at the expense of our patients.

As a practice, we would like to continue to extend the benefit of participating as a preferred provider with your specific dental plan but without compromising the quality and level of service we are always dedicated to serve you with.

For procedures such as composite fillings, cosmetic dental bonding, porcelain full or partial coverage restorations, or for all cosmetic procedures, there is an additional cost per tooth treated that is not covered by your dental benefit provider. The cost is determined based on the specific procedure being performed as written and specified on the treatment plan.

We have previously communicated extensively with your insurance company about these extra steps and quality measures we take on each procedure with our patients. Although they recognize the dental codes for each of these procedural steps, your insurance company doesn't provide any payment for them.

Dental research is very clear that these extra, but fundamental steps is for the most part what makes the difference in the final result when it comes to longevity and esthetics of the restoration and long term effect to the tooth (long term sensitivity and protection of the remaining tooth structure).

We will always strive to stay up to date with the best practice methods and procedures regardless of what or how much your dental insurance will reimburse.

I have read and understand the above.

_____
Print Patient Name

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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Patient Acknowledgement of Receipt of Notice of Privacy Practice

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I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practice explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

KEA Smile Studio, PLLC
1502 W Fletcher Ave, Suite 117
Tampa, FL 33612

I may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient of Personal Representative

Signature: _____ Date: _____

Name: _____
(Please Print)

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s Receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) _____.
☐ Communications barriers prohibited obtaining an acknowledgment.
☐ An emergency situation prevented us from obtaining an acknowledgment.
☐ Other _____

KEA SMILE STUDIO PLLC

Broken Appointment Informed Consent

Patient Full Name	***Address***		
Date of Birth	***City***	***Sate***	***Zip***

We promise to make every effort to respect your time and we ask that you please respect our time. We reserve personalized time for you to receive the one-on-one attention you deserve. **Our office requires a 48-hour notice of cancellation during normal office hours (Monday appointments must be cancelled by 9am Thursday morning).** Advance notice from you allows us adequate time to make arrangements to care for another patient in the time we had reserved just for you.

If our office does not receive proper notice, you may be charged **$50.00 per hour** of treatment missed. We understand emergencies happen and our broken appointment agreement will not apply in these cases.

In addition, if your appointment is not kept or rescheduled and we are not notified two business days in advance, we will request your credit card number on file in order to reschedule your appointment. Should you fail to keep your next reserved appointment time or fail to give us two business days' notice to reschedule, your card will be charged for the amount of services rendered at the next scheduled appointment.

Broken appointments are a loss to everyone. Unfortunately, whenever an appointment is missed, our overhead expenses continue to rise and we are unable to fill the open time due to the lack of sufficient notice. Instead of increasing our fees to everyone, we have created this agreement for the very few that may not understand.

We appreciate all of our patients and it is not our intent to offend anyone. With your compliance, we will be able to keep our schedule on time, accommodate any emergencies and help patients on our waiting list. We thank you for your understanding and cooperation in this matter.

Informed Consent: I have read, understand, and agree to the broken appointment agreement.

Signature of Patient or Authorized Representative	Date

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Photography and Video Release Form

I/We hereby irrevocably grant KEA Smile Studio, PLLC; permission to use, publish, copyright, and/or reproduce in any form all photographs, videos or statements made of me this day and throughout the course of treatment, without further compensation to me. All negatives and positives shall be considered the property of KEA Smile Studio, PLLC; solely and completely. We agree that any disputes arising from the agreement will be settled under applicable Florida Law.

I am 18 years of age (circle one): Yes No

If under 18, a parent or guardian must sign the appropriate section below

Patients Name:_____

Signature: _____

Print Name: _____

Parent/Guardian Signature (if under 18): _____

Parent/Guardian Print Name: _____

Witness Signature: _____

Date: _____

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Credit Card Authorization Form

Account Number: _____ Date: _____

Patient Name: _____

Name on Card: _____

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex ☐ CareCredit

Card Number: _____

Expiration Date: _____

Security Code: _____

Address: _____

City, St, Zip: _____

Phone No: _____

Payment Amount: $_____

By signing this document, I hereby give permission and authorize **KEA Smile Studio** to process payment for dental appointments, by keeping my information on file for any future appointments or account balances. I understand that my credit card will not be charged unless treatment has been rendered. I understand that should I have insurance and the insurance company not pay as estimated, that I will be contacted for payment approval.

_____ _____

Signature of Patient or Authorized Representative Date

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