

**PATIENT INFORMATION
FOR THE PRACTICE OF DON J. PISCIOTTA, D.D.S.**

DATE: _____

PATIENT NAME: _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
BUSINESS PHONE _____ EMAIL ADDRESS _____
DATE OF BIRTH _____ SS# _____
NAME OF SPOUSE _____ SPOUSE SS# _____
SPOUSE DATE OF BIRTH _____
REFERRED BY _____
PHARMACY NAME _____
EMERGENCY CONTACT/PHONE _____

INSURANCE INFORMATION

SUBSCRIBER NAME (POLICYHOLDER) _____
EMPLOYER NAME _____
DENTAL INSURANCE COMPANY _____
GROUP NUMBER _____
ADDRESS _____
PHONE _____ FAX _____

PLEASE READ THOROUGHLY:

ALL CO-PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED. As a courtesy to our patients we will file your insurance claims for you. Please be sure that we have the most current insurance information on file for you. After your claim has been submitted to your insurance company twice, and payment has not been received, the balance becomes the patient's responsibility and payment is expected **promptly**. In the event that we received payment from the insurance company as well as from the patient, reimbursement will be made to the patient. Please sign below to acknowledge acceptance of this policy.

PATIENT NAME (OR PARENT/GUARDIAN IF PATIENT IS A MINOR)

PAYMENT OPTIONS

Forms of payment accepted by Dr. Pisciotta include Cash, Check, Visa, MasterCard and Care Credit. The Care Credit option is an interest free payment plan, and must be utilized and approved **before** treatment is performed. For more information on the Care Credit option, please inquire at the front desk.

CONFIRMATION AND CANCELLATION POLICIES

We confirm our appointments by phone, either at the home number or the cell number that you prefer. We require a 24-hour cancellation notice for all appointments. We understand that there may be unforeseen circumstances that require you to cancel your appointment less than 24 hours ahead. **Please note that if you have a dental appointment on a Monday, 24 hours cancellation notice must be given on the Friday before, by the same time of your appointment.** However, if you have broken 2 or more appointments without notification to our office, a non-refundable broken appointment fee of a minimum of \$75, or the equivalent of 25% of Dr. Pisciotta's procedure fee, will be applied to your account. In addition, if you are more than 15 minutes late for your appointment, you may be asked to reschedule. Please sign below to indicate your acceptance of this policy.

PATIENT NAME (OR PARENT/ GUARDIAN IF PATIENT IS A MINOR)

PATIENT PRIVACY PRACTICES

AS of April 14, 2003, we are required by law to institute certain privacy practices to protect patient health information under The Health Insurance Portability & Accountability Act (HIPAA). You are entitled to a copy of our Notice of Privacy Practices, which are also posted in our waiting room. We are required to obtain from you a Notice of Privacy Practices Acknowledgement form to retain for our records. You will find both of these forms attached. Please retain the Notice of Privacy Practices for your records, and return the Acknowledgement form to our front desk. In the event that you need to amend any information in your patient record, or have any information released to you, other health care providers, schools or colleges, etc., you will be asked to sign a consent form, which will remain a part of your record in our office. All of your information is intended for use in our office only, but also allows us to send mass mailings such as statements, recalls, etc. Please sign below to indicate your acceptance of this policy.

PATIENT NAME (OR PARENT/GUARDIAN IF PATIENT IS A MINOR)