DREW BEATY DDS
family and cosmetic dentistry

Financial Policy And Agreement

Outstanding Patient Service is Our Goal

The goal of Dr. Beaty and team is to make sure that you receive the highest quality dental care and service. One step is to make certain that our financial policies are clear and understood by you.

Insurance – We go the Extra Mile

If you have insurance, we will make a good faith estimate of your benefits. We will take complete care of completing and filing the appropriate claim forms with your insurance company. We will also track your claim and make sure that it is paid in a timely manner. We will follow up with your insurer when claims are not processed efficiently and attempt to expedite payment. We are also happy to provide your insurance company x-rays or other information they may require.

If your insurer denies coverage, or if we otherwise do not receive payment from your insurance company within 60 days from filing your claim, the balance amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. **Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.**

Your Payment is Due at the Time of Treatment

Fees for treatment are due at the time of treatment after deduction of your good faith estimate of insurance benefits as described above.

Payment Options:

Cash *Check* *Visa* *MasterCard* *Care Credit (Third Party Financing with a short application)*

Patient Responsibility

I acknowledge my responsibility for payment of the services received from Dr. Beaty in accordance with Dr. Beaty's regular fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part of none of the charges.

I understand that this account becomes delinquent if not paid within 60 days after billing and that at that time a Finance Charge of 1.5% of the unpaid balance will be charged every month until balance is paid in full.

Assignment and Release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier.

Patient Signature: _____ Date: _____

Staff Member's Initials: _____ Date: _____

Dr. Drew Beaty Personal and Innovative Care Today's Date: _____

Patient Medical Information

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

Name: _____ Age: _____ Date of Birth: _____

Physician's Name and Address: _____

_____

Physicians Phone: _____ Date of last visit: _____

ALLERGY PROBLEMS

Asthma	Yes	No
Hay Fever	Yes	No
Sinus Problems	Yes	No
Skin Rashes	Yes	No

BLOOD PROBLEMS

Abnormal Bleeding	Yes	No
Blood Disease/Anemia	Yes	No
Easy Bleeding	Yes	No
Frequent Nosebleeds	Yes	No

BONE OR JOINT PROBLEMS

Arthritis	Yes	No
Joint Replacement	Yes	No
Osteoporosis	Yes	No
Back or Neck Pain	Yes	No

HEART PROBLEMS

Chest Pain	Yes	No
Heart Murmur	Yes	No
Heart Valve Problem	Yes	No
High Blood Pressure	Yes	No
Pacemaker	Yes	No
Rheumatic Fever	Yes	No
Shortness of Breath	Yes	No
Heart Attack	Yes	No
If yes, date:		
Stroke	Yes	No
If yes, date:		

INTESTINAL PROBLEMS

Special Diet	Yes	No
Ulcers	Yes	No
Weight Gain/Loss	Yes	No

OTHER

Cancer/Tumor	Yes	No
Treatment dates:		
Diabetes	Yes	No
Epilepsy/Seizures	Yes	No
Glaucoma	Yes	No
Hepatitis	Yes	No
If yes, type:		
Other Liver Problems	Yes	No
If yes, type:		
Herpes	Yes	No
HIV/AIDS	Yes	No
Tuberculosis	Yes	No
Other Respiratory Problems	Yes	No
Venereal Disease	Yes	No
Do you smoke?	Yes	No
If yes, how much?		
Do you consume alcohol?	Yes	No
If yes, how much?		

Are you seeing a physician for the treatment of a medical condition?

Have you been hospitalized in the last year?

Have you ever been advised to take an antibiotic prior to a dental appointment?

WOMEN

Are you pregnant?	Yes	No
If yes, approx. due date:		
Are you taking contraceptives?	Yes	No
Other hormones?	Yes	No

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ALLERGIES

Are you allergic to or have you reacted adversely to any of the following?

Local Anesthetics	Yes	No
Penicillin or other antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives or sleeping pills	Yes	No
Aspirin	Yes	No
Acetaminophen	Yes	No
Ibuprofen	Yes	No
Codeine	Yes	No
Metals	Yes	No
Latex	Yes	No

Other:

_____

_____

MEDICATIONS

List medications you are currently taking, both prescription and over the counter:

_____

_____

_____

_____

_____

_____

_____

Are you currently taking any herbal or natural homeopathic remedies?

OTHER MEDICAL PROBLEMS OR CONDITIONS

_____

_____

_____

_____

_____

_____

_____

NOTES:

I certify that the above information is complete and accurate.

Signature: _____

Date: _____

Dentist's Signature: _____

Date: _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Robert Andrew Beaty, DDS
31003 Pacific Hwy S
Federal Way, WA 98003
253.839.6544

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

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PATIENT RECORDS REQUEST FORM

Name of Patient Whose Record is Requested:_____

DOB:_____Phone:_____

Address:_____

Please provide a copy of the record as indicated below:

___ The full health record maintained by this provider/practice

___ The health record for the following time frame:_____

___ A specific section of the health record as described below:

_____

_____

_____

___ A summary of the information requested above is adequate to fulfill this request.

___ As permitted by federal and state law, I understand that a fee of _____per page will be charged for copying the records, along with a clerical fee of _____. In addition, a fee of _____ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive a copy of this record.

Signature of Patient _____

Signature of Authorized Personal Representative_____

Relationship to Patient_____

Date:_____

Drew Beaty, DDS 31003 Pacific Highway South Federal Way, WA 98003 *253-839-6544 fax 253-839-9060 email: nfo@drewbeatydds.com

Medical Alert for Office Use

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Patient Information

Please Print

Last: _____ First: _____ Middle: _____ Preferred: _____
Street: _____City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ May we contact you by email? (circle) **Yes No**
Date of Birth: _____ Social Security Number: _____ Sex: (circle) **M F**
Employer: _____ Position: _____
Emergency Contact: _____ Phone: _____

Insurance Information

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card and photo I.D. to our patient services representative to be photocopied			

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the office of Dr. Robert Beaty of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dr. Beaty's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Guarantor Signature: _____ Date: _____

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated.

- Payment for all treatment and services rendered are my responsibility.
- A notice of 2 business days to cancel or reschedule an appointment is required, or a fee may apply.

_____ _____
PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

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SCHEDULING POLICY

Thank you for choosing the office of Dr. Robert Beaty to care for your dental health needs. Your success relies heavily on your participation in treatment, at home dental care and in attending your appointments.

We are committed to serving our patients. To help us do this we ask for **2 working days advance notice** to cancel or reschedule an appointment. This enables us to contact and schedule patients who are on a wait list.

We reserve the right to charge a $50 per hour fee for any broken appointments. If you have two or more broken appointments, we also reserve the right to place you on a "same day only" scheduling status and cancel all future appointments.

*We understand that extenuation circumstances may arise, so please discuss this with our office staff if you need to make special scheduling arrangements.

I have read the above and agree to its terms.

_____ _____

Patient and/or guardian Date

31003 Pacific Highway S, Federal Way, WA 98003
P: 253.839.6544 F: 253.839.9060 E: info@drewbeatydds.com W: drewbeatydds.com