Court Street Dental, PC

Patient Registration

Date____________________ (please print) Home Phone (_____) ________________________

Patient Name Last________________________ First____________________ M.I._____ Preferred_____________________

Street Address _______________________________________ City______________________ State______ Zip____________

E-mail____ Cell Phone (_____) __________________________________

Sex ___ M ___F Age_______ Birthdate__________ ___Married ___Widowed ___Single ___Minor

___Separated ___Divorced ___Partnered for ____ Years

Employer/School_____________________________________ Occupation____

Employer/School Address____ Employer/School Phone (_____) _______________

Spouse/Parent Name__________________________________ Spouse/Parent Employed by___________________________

Who is responsible for this account? ______________________ Relationship to Patient________________________________

Social Security #______________________________________ Spouse/Parent's Social Security #______________________

Name of Dental Insurance Company____ Group Number___________________

In case of emergency, who should be notified?________________________________ Phone (_____)___________________

Who may we thank for referring you? ____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received and understand the Notice of privacy Practices. The notice provides in detail the uses and the disclosures of my protected health information that may be made by this practice, individual rights, how I may exercise these rights and the practice's legal duties with respect to my information. I understand that the practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes of the policy occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

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Signature of patient or parent (if minor) Date

Court Street Dental

310 E Court Street | ITHACA NY, 14850 | (607) 272-2033

Written Financial Policy

Thank you for choosing Court Street Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Court Street Dental requires payment at time of service.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

There is a $40 fee for patients who "no-show" for their appointments.

There is a 1.5% monthly fee for accounts 60 days past due.

Court Street Dental charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature   Date

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Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.