306 S. 4th Street Ste. 100
Seward, NE 68434
Ph. (402) 643-2931 Fax (402)643-4258
Email: office@sewarddentalclinic.com

Patient Information

First Name:______________________ Middle:____________ Last:____________________________

Address:__________________________________ City:_______________ State:_____ Zip:_________

Home Phone:___________________ Cell Phone:__________________ Email:___________________

Birthdate:_______________ Marital Status: (please circle one) Single Married Divorced Widowed

Employer:______________________________ Position:___________ Work Phone:_______________

Referred by:____________________________ Emergency Contact:____________________________

Responsible Party Information

Name of Responsible Party (if different than patient):____

Relationship to patient:____________________ Contact Number:_____________________________

Address:__________________________________ City:_______________ State:_____ Zip:_________

Employer:______________________________ Position:___________ Work Phone:_______________

Dental Insurance

Name of Insured:_________________________________ Relationship to Patient:________________

Birthdate:____________ ***Social Security Number**:______________Employer:_________________

Insurance Carrier:________________________________ Phone:______________________________

Claim Submission Address:____

City:_______________________________________ State:__________ Zip:____________________

Member ID #:_____________________________

Secondary Insurance Carrier (if applicable):______________________________ Phone:___________

Address:__________________________________ City:_______________ State:_____ Zip:_________

Name of Insured:_________________________________ Relationship to Patient:________________

Birthdate:____________ Social Security Number:________________ Employer:__________________

Member ID #:_____________________________

Patient or Guardian Signature:____

Seward Dental Clinic Financial Policy

We, at Seward Dental Clinic, are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. In order to assist you with your health care investment, we are providing the following payment options.

PAYMENT:

Payment is due at the time of service. We do accept cash, personal checks with current date, major credit cards, debit cards and third party financing through Care Credit.

INSURANCE:

As a courtesy to our patients, we are happy to file your claims on your behalf. We are currently contracted as In-network with BCBS of Nebraska, Delta Dental Premier, Cigna, and United Concordia. All other insurance companies' claims will be processed as an out of network provider. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are estimates only, they are not a guarantee of payment. The patient is ultimately responsible for all charges incurred. Our first and only priority is our patients and the quality of care. The negotiation of benefits is between you, your employer and insurance company.

RETURNED CHECKS:

All returned checks are subject to a $30.00 returned check fee. Any unpaid returned checks will be forwarded to the District Attorney for collection.

DELINQUENT ACCOUNTS:

Accounts over 90 days past due will be referred out for collection and the patient is responsible for any fees associated with that process, unless previous arrangements have been made.

CANCELLATION POLICY:

It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities. We do require 24 hours notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. We are then also able to offer all of our patients' the same exceptional standard of care.

FINANCING OPTIONS:

Ask our team how we can help you with your financial needs. We offer some deferred interest plans through Care Credit. We will be happy to help you with this. Financing your treatment will allow you to begin your treatment immediately and spread the cost over a period of time.

I have read the above and understand and agree to these terms. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of benefits to be directly to SEWARD DENTAL CLINIC.

____ ________________________

Patient/Responsible Party Date

HIPAA Acknowledgment Form

I give permission to discuss my account and dental records with my immediate family, as in my spouse, parents, or children as designated by responsibility for scheduling or payment of my account.

List of family member/s and relationship given consent:

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I give permission to discuss my account and dental records with my immediate family, as in my spouse, parents, or children as designated by responsibility for scheduling or payment of my account.

I understand that in compliance with HIPAA law, I may make specific amendments to what information is released and to whom, and may revoke all or part of this agreement in writing at any time.

I have been informed of the HIPAA Omnibus Privacy Act and received a copy (if requested). I have also been informed that I will be notified by this office if my personal health information is subject to a breach in privacy.

______________________________ ________________________

Printed Name

______________________________ ________________________

Patient Signature Date

______________________________ ________________________

Parent or Guardian signature (if minor) Date