Patient Name:
Patient DOB:
Date:

KEYSTONE
ORAL SURGERY & IMPLANT CENTER

Patient, Pharmacy and Insurance Information

Patient Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Date Of Birth: _____ Sex: Male ☐ Female ☐ Unspecified ☐
Preferred Phone #: _____Is this a **mobile** number? **Yes ☐ No ☐** **May we text: Yes ☐ No ☐**
Email Address: _____ May we email you to communicate: Yes ☐ No ☐
Emergency Contact: _____ Emergency Phone #:_____
Purpose of the visit: Emergency ☐ Extraction ☐ Implant ☐ Other ☐
Do you need Translation services: Yes ☐ No ☐ (We use Cyrocom Services for Translation Services)
Would you like to use family/Friend for translation: Yes ☐ No ☐ Na

Preferred Pharmacy

Note: When a prescription for narcotic pain medication is sent to a pharmacy, it generally cannot be canceled or transferred to another pharmacy.
Name: _____Phone: _____
Street: _____ City: _____ State: _____ Zip: _____

Responsible Party:

First Name: _____ Middle Name: _____ Last Name:_____
Street: _____ City: _____ State: _____ Zip: _____
Date Of Birth: _____ Relationship to the Patient: _____Sex: Male ☐ Female ☐ Unspecified ☐
Responsible Party Signature: _____ Date:_____

Dental Insurances (Primary)

Is the Subscriber same as the Patient: Yes ☐ No ☐
Subscriber Information:
First Name: _____ Middle Name: _____ Last Name: _____
Employer Name: _____ Insurance Company: _____ Ins Ph#:_____
Subscriber ID/Policy Number: _____ Group/Contract Number: _____Date of Birth: _____
Patient Relationship to Subscriber: ☐Child ☐Disabled Dependent ☐Spouse ☐Self ☐Other Dependent
Subscriber SSN: _____

Secondary Insurance (If applicable)

Is the Subscriber same as the Patient: Yes ☐ No ☐
Subscriber Information:
First Name: _____ Middle Name: _____ Last Name: _____
Employer Name: _____ Insurance Company: _____ Ins Ph#:_____
Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____
Patient Relationship to Subscriber: ☐Child ☐Disabled Dependent ☐Spouse ☐Self ☐Other Dependent
Subscriber SSN: _____

By signing below, I acknowledge that I have read, understand, and agree to the information provided above

Patient/Guardian signature_____ Date:_____

Patient Name:
Patient DOB:
Date:

KEYSTONE
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Agreement of Financial Responsibility

Thank you for choosing Keystone Oral Surgery Associates provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

1. Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider applicable.
2. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. **Some procedures and diagnostic test may not be covered by your plan these may include, but not limited to Beam Computed Tomography (CBCT) scans, Surgical procedures (e.g., tooth extractions, dental implants, bone grafting), Diagnostic procedures (e.g., biopsies, advanced imaging)**
3. We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage, should you fail to provide this information, you will be financially responsible.
4. If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
5. If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit, we will provide you with a statement that you can submit to your insurance company for reimbursement.
6. Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
7. Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher copayments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in

Signature of Patient /Responsible Party: _____ Date: _____

Name of Patient /Responsible Party(Please Print): _____ Relationship: _____

Patient Name:
Patient DOB:
Date:

KEYSTONE
ORAL SURGERY & IMPLANT CENTER

Cancellation and Rescheduling Policy

This policy is designed to respect both the clinic's time and other patients' needs. We appreciate your understanding and cooperation.

To ensure efficient service for all our patients, please adhere to the following policy:

1. IV Sedation Appointments:
    - A 72-hour advance notice is required for cancellation or rescheduling.
    - A fee of $150 per 30 minutes of scheduled appointment time will be charged for late cancellations or no-shows.
2. Rescheduling After a No-Show:
    - Appointments can be rescheduled after a 2-week waiting period.
    - A $150 fee must be paid at the time of rescheduling.
    - The doctor will see you on the rescheduled date if time permits.
3. Pre-Sedation Instructions: (All necessary forms and instructions will be provided during your consultation)
    - Failure to follow pre-sedation instructions will result in rescheduling.
    - The next available appointment will be after 2 weeks.
    - A fee of $150 per 30 minutes of the original appointment time will apply.

We understand that emergencies may arise. Please contact our office immediately if you need to cancel or reschedule. Adherence to this policy helps us provide timely care to all our patients.

By signing below, I acknowledge that I have read, understand, and agree to this cancellation and rescheduling policy.

Patient Name (Print): _____Patient Signature: _____ Date: _____

Patient Name:
Patient DOB:
Date:

KEYSTONE
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish. (Privacy Policies are provided).

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____ _____

Signature *Date*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____

_____

_____ _____

Employee signature *Date*