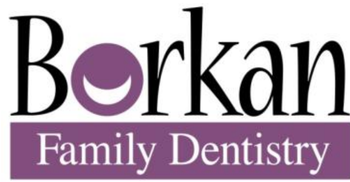


Welcome to our Practice

Thank you for choosing Borkan Family Dentistry for your dental care.

We are dedicated to providing you and your family with the most up to date and professional care in a relaxing comfortable environment. To avoid any confusion, we have listed below our office policies and procedures: *This form must be read and signed before any treatment is rendered*.

Appointments

In order to provide quality, professionalism and effective care, we utilize an appointment schedule. Our aim is to provide you all the scheduled time and attention while you are in our office. However, if you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. We are available when emergencies arise, and will do our best to give prompt consideration as needed.
Unfortunately our staff members will not be able to provide childcare and not responsible for any minor child left alone in the waiting area during your appointment. Please make arrangements for your childcare, failing to provide appropriate care might require us to cancel your appointment and charge a fee for missed appointment.

Minor Children Appointments

We are requiring legal guardian to be present at the children's appointment if they are under age 18. We need you to remain in the building for the entire appointment. We provide children with the same care that our adult patients receive and prefer to care for them as individuals.

Cancellation Policy

As a courtesy, Borkan Family Dentistry will try to remind you your existing appointment, please inform us as soon as you can if your contact information has changed. In order to cancel your appointment, please notify our office at least forty eight (48) hours in advance of your scheduled appointment time. Appointment changes can only be made during our regular office hours. You may be charged a fee for not providing a forty eight (48) hour notice of cancellation or failing to show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $50.00. Two (2) missed appointments may lead to an inability to schedule you for future appointments.

Your cooperation is greatly appreciated; please ask us questions if you do not understand any of these policies.

Patient Name: ____

Guardian Name for Minor Children: ____

Patient or Guardian Signature ____

Date: ____

Financial Agreement

If you do not have insurance; all payments are due at the time of the service.
If you have insurance it is a contract in between you, your employer and insurance company. we are happy to help you filing your insurance for most of the dental procedures. But please understand that we cannot speak on their behalf and cannot be responsible for settling any disputed coverage and claims.

We suggest you to verify your benefits before you arrive to your appointment.

We require payment of estimated patient portion at the time of the service.
Our office policy states that you are solely responsible for your acquired cost related to the services rendered in our office.

We will inform you if your insurance company payment not received within 30 days and we will bill you directly.

I understand that my insurance policy is a contract between myself and the insurance company, and Borkan Family Dentistry is not a party to that contract. I am responsible for unpaid balances and non-covered services, which may result in additional fees. I am responsible for informing the office of all changes to my information and insurance prior to my appointments. Insurance must be in force and verifiable at time of treatment, and if I do not have insurance, I agree to pay in full at the time of the appointment.

Balances over 30 days may be subject to 2% late payment fee per month.

I hereby assign all insurance benefits for services rendered, otherwise payable to me, directly to Borkan Family Dentistry from Medicaid or my private insurance.
I authorize Borkan Family Dentistry to release medical information to my insurance company, its agents or any third party for use in determining my benefits.
If my account enters a delinquent status, I agree to pay all costs of collections including attorney fees and court fees, if applicable.
If my account enters court collection status, I accept that I will no longer be a patient of record.
I understand that the fee for a returned check is $35.

Medicaid Insurance

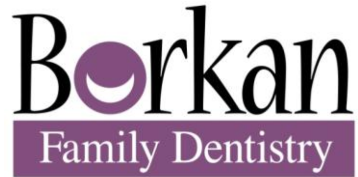
If you have Medicaid insurance, you must have your card, picture ID, and your required co-pay ($3-$5).
If you do not have all of these requirements we will have to reschedule your appointment.

Patient Name: ____

Guardian Name for Minor Children: ____

Patient or Guardian Signature ____

Date: ____



Full Name: ____

Preferred Name: ______________________ Date of Birth: __________________________

Email Address:____

Address: ____

City: _________________________ State: _____ Zip Code: _________________

Telephone: Home ______________________________

Work ______________________________

Mobile ______________________________

Social Security # ________________________________

Driver's License # ________________________________

Occupation____

Employer____

Gender_______________Age____________Height________________Weight__________

*Emergency contact name:____

*Phone: home _____________________________ cell _____________________________

Whom we can thank for referring you to our practice?

Name: ____

GUARDIAN OR RESPONSIBLE PARTY (if someone other than the patient)

Full Name____

Relationship_______________________ Date of Birth: ____________________________

Email Address ____

Address ____

City __________________________ State ______ Zip Code _______

Telephone: Home ___________________

Work ___________________

Mobile ___________________

Social Security #: ____

Driver's License#: ____

Occupation____

Employer____

PRIMARY INSURANCE POLICY

Name of Insured____

Date of Birth ____

Social Security____

Employer____

Insurance Company____

Address____

Policy#______________________________ Group# _______________________________

Phone#______________________________ Provider #_______________________________

Compound Authorization Form

Name of Patient: ____ **Date of Birth:** ____/____/______

The purpose of this authorization is to inform the patient or others with pertinent patient information. The patient has requested that Borkan Family Dentistry is to release the following information about the above named patient to the entities named below:

____ **Voice Mail** and/or Answering Machine phone number________________________

____ **Email** email address____

____ **Text message** phone number________________________

____ Appointments ____ Instructions (Pre/Post Procedure/Operation)

____ Financial ____ Lab/test results ____ Medical______________________

____ NPP ____ Breach information details

____ **Spouse** Name____________________________ phone number____________________________

____ **Other** Name____________________________ phone number ____________________________

____ Appointments ____ Instructions (Pre/Post Procedure/Operation)

____ Financial ____ Lab/test results ____ Medical______________________

Right of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Borkan Family Dentistry. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as result of this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ Date_____________________

Signature of Patient or Legal Representative

____

Description of Legal Representative Authority (provide supporting documentation)

Borkan Family Dentistry
1617 Ronald Dr.
Raleigh, NC. 27609
(919) 790 2220
info@borkanfamilydentistry.com

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 of receipt but we must keep a record of your refusal. If you refuse to sign this acknowledgement of receipt, we are required to treat you and we may still use and/or disclose your health information as HIPAA permits.

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

Print Name: ____

Signature: ____

Date: ____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or 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 acknowledgement
- We were unable to communicate with the patient
- Other (provide specific details)

  ____
  ____
  ____

____ ____________________

Employee signature Date

HIPAA Acknowledgment of receipt of the Notice of Privacy Practices

This form does not constitute legal advice and only covers federal, non-state laws.