cohen moderndentistry
JASON M COHEN DDS

To the best of my knowledge, all of the information on this health history form is true and correct. If there is any change in health, or my medications, I will inform Dr. Cohen and/or dental staff prior to any treatment.

Signature _____ Date _____

We would like to take this opportunity to welcome you to our practice and provide you with information to help prevent any misunderstandings.

OUR OFFICE HOURS:
Monday 8:00 a.m.- 5:00 p.m.
Tuesday - Thurs 7:00 a.m. - 4:00 p.m.
Friday: CLOSED
Saturday CLOSED
Sunday CLOSED

In the event of a serious dental emergency (a large amount of swelling or pain) after hours, you may leave a message on Dr. Cohen's emergency voicemail (734-283-1263), and he will attempt to return your call promptly. If Dr. Cohen is unable to contact you within an hour, please contact and go to your closest emergency facility immediately. We are committed to provide the highest standard of care possible. If you have dental insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. PAYMENT/CO-PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. For your convenience we accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit. I authorize Cohen Modern Dentistry, P.C., to provide my insurance company(ies), claim administrator(s), other third-party payers and consulting healthcare professional(s), information concerning health care, advice, treatment or supplies provided to me or the patient. In the event that the patient is a Minor, I represent that I am the parent and/or legal guardian of the Minor. This information will be used exclusively for the purpose of evaluating and administering claims for benefits and as otherwise permitted by the Practice's HIPPA policy or under law. I further authorize payment directly to the practice. I agree that a photocopy of this authorization is as valid as the original. I further acknowledge having received a copy of the Practice's Notice of Privacy Practices.

Patient signature (if patient is a minor, Parent or Legal guardian must sign here and complete section below)

Signature _____ Date _____

PAYMENT AGREEMENT:

I agree that I am responsible for all services rendered to the patient and the payment is due and payable to the Cohen Modern Dentistry, P.C. at the time services are rendered and that health, dental and accident Insurance policies are an arrangement between my insurance carrier and me (the patient). I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the dental practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid to it by my insurance company. I also understand that if the Practice cannot verify insurance benefit eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered.

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I understand that the Practice may charge:

1) a finance charge of 1.5% if the payment on my account is not received by the due date;

2) a $35.00 fee for each returned check,

3) A CHARGE OF $42.00 PER 30 MINUTES OF BROKEN APPOINTMENT TIME FOR ANY APPOINTMENTS THAT ARE NOT CANCELLED 48 BUSINESS HOURS IN ADVANCE. For example, if you have a Monday appointment you need to cancel, you must cancel at least by the prior Wednesday, 48 office business hours before the Monday appointment time in order not to be charged.

I agree to the extent permitted by law that if my account is referred to any agency or attorneys for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I, the patient have been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 20___.

Patient Signature_____