DRS. DALE and ROBERT COLLINS

DATE: _____

Child 's Name _____ Age ____ Birthdate _____ Sex: M___F___

Nickname_____ Family Name _____

Father's Name_____	Mother's Name _____
Social Security #_____-_____-_____	Social Security # _____-_____-_____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Father's Occupation_____	Mother's Occupation_____
Name of Employer _____	Name of Employer _____
Street _____	Street _____
_____	_____
City State Zip	City State Zip

Person Responsible for Account: Father _____ Mother _____ Other _____

If other, please identify: _____

Is child covered by any DENTAL insurance? YES / NO If YES:

Father's Insurance _____	Mother's Insurance _____
Group #_____	Group #_____

Is this the child's first visit to a dentist YES / NO

If no, child's previous dentist _____

Are any other family members a patient in this office? YES / NO

Is there now or has there ever been any of tile following? (CIRCLE)

CAVITIES TOOTHACHE PAIN BROKEN TOOTH EXTRACTED TOOTH STRAIGHTENED TEETH GUM INFECTION

Other: _____

Child's Physician: _____

Is the child ALLERGIC to any medication? _____ If yes, please explain _____

_____

Is the child taking any medicine? _____ If yes, please explain _____

Has the child had any history of: (circle those that apply)

Anemia	Emotional Problem	Heart Trouble	Rheumatic Fever
Asthma	Epilepsy	Kidney Disease	Speech Impediment
Tumors	Convulsions	Liver Disease	Tuberculosis
Diabetes	Excessive Bleeding	Hearing Problem	Mental Disturbance

Other: (explain) _____

If the patient is a teenager and there is any possibility of pregnancy, it is very important that you inform this office prior to treatment.

Please be aware that pediatric dentists routinely use nitrous oxide analgesia on children for restorative procedures in addition to a local anesthetic.

Whom may we thank for referring you to our office? _____

_____

Signature of Father or Guardian Relationship to Child

_____

Signature of Mother or Guardian Relationship to Child

Financial Policy – Dr. Robert M. Collins and Dr. Dale R. Collins

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete our patient information and medical history forms, read and approve our privacy policy and submit your insurance card for photocopying. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Your appointment time is reserved exclusively for you. If you cannot keep your appointment, you must provide our office with a 24-hour notice to avoid a broken appointment fee of $50.00.

We will do everything we can to inform you in advance of the anticipated costs of your treatment, including an estimate of the benefit your insurance company is likely to pay. Such information does not preclude the possibility that additional costs may be incurred if unanticipated treatment becomes necessary, nor will it absolve you of your obligation to pay for such treatment. Keep in mind that your treatment needs are not connected to or determined by your insurance benefits.

Insurance is a contact between you and your insurance company. Not all services are a covered benefit in all contracts. We file insurance claims as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered services, "usual and customary" allowances or other issues other than to provide factual information as necessary. **You, the patient, are ultimately and completely responsible for payment of your account.**

Insured patients are required to pay the **estimated** cost of their care at the time of the service. If you do not have insurance, or if your insurance will not reimburse us directly (for example: Out-of-State Blue Cross Blue Shield), payment in full is expected at the time of service, unless otherwise arranged in advance. There are payment options available for those who are unable to pay in full at the time of service. These options must be agreed upon prior to treatment being rendered. Please ask a member of our staff to further elaborate.

During the normal course of business we, or our agent, may pull your Credit Report. The purpose of this is to verify identity in an attempt to reduce fraud. This office does not extend credit so your Credit Source is irrelevant to us.

Interest at the rate of 1 ½% per month will be added to your account until the balance has been paid in full. A non-sufficient funds (NSF) fee of $50.00 will be added for each dishonored check. It is your responsibility to pay for any costs of collection including, but not limited to court costs, collection agency fees and/or attorney's fees, incurred by this office, our agency or our assignee.

If an account is referred to, or purchased by, a collection agency, a fee will be assessed (33.3% of the outstanding balance) and added to your ledger. In addition, you will be responsible for any fees added by or incurred by the collection agency collecting this debt, including, but not limited to: interest fees at 2% per month, court costs, US postage, certified mail costs, credit report/skip-tracing costs, courier service and process server fees.

If there is ever a dispute with respect to the amount owed on your account, you must notify this office, in writing, within 30 days of invoice date. For our mutual records, we suggest you send this via certified mail.

I have read the above policy and understand my responsibility for my account. **I, the patient, am ultimately and completely responsible for payment of my account and agree to the above terms.**

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Complete Printed Name-First/Middle/Last Social Security Number

Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Robert M. Collins, D.D.S, P.A.

_____ _____

Signature of Patient or Responsible Party Date

DALE R. COLLINS, D.D.S.
ROBERT M. COLLINS, D.D.S.

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my insurance carriers.
I authorize my doctor to act as my agent in helping me to obtain payment from my insurance carriers.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
I authorize my employer to release information concerning my employment.
I understand that there may be a charge for any missed appointment without 24 hour notice and that, in compliance with the Federal Lending Laws, we have the prerogative of charging a 1½% service charge per month on all delinquent accounts.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Mother's Name _____ Father's Name _____
Please Print Please Print

Mother's Signature _____ Father's Signature _____

Dr. Robert Collins, DDS, PA

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: Chelcie

Address: [redacted]

Telephone: [redacted] E-mail: [redacted]

Patient #: [redacted] Social Security #: [redacted]

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Robert M. Collins, DDS, PA

Telephone: (302) 239-3655 Fax: (302) 239-3661

E-mail:

Address: 5500 Skyline Drive, Suite #3, Wilmington, Delaware 19808

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I [redacted], have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: [redacted] Date:

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient: [redacted]

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.