KRISTEN J. MORGAN
D.D.S, P.C.

CONFIDENTIAL PATIENT INFORMATION

Legal Name:		
I prefer to be called:		
Mailing Address:		
City, State, Zip:		
Email:		
Home Phone:	Work Phone:	Cell Phone:
Date of Birth:	Social Security #:	
Preferred Contact:	☐ Home ☐ Work ☐ Cell ☐ Email ☐ Other	
Marital Status:	☐ Married ☐ Single ☐ Widowed ☐ Other	
Sex:	☐ Male ☐ Female	
Employer:	Referred By:	
Interests:		
Emergency Contact (name, relationship, phone#):		

RESPONSIBLE PARTY (if patient is minor)

Name:	
Mailing Address (if different from above):	
City, State, Zip:	
Email:	
Employer:	
Relationship:	Social Security #:

INSURANCE INFORMATION (if applicable)

Subscriber's Name:	Member/Group ID:
Date of Birth:	Social Security #:
Employer:	Insurance Company:

SIGNATURE OF PATIENT/GUARANTOR _____ **DATE**_____

RELATIONSHIP TO PATIENT_____

3080 N Lake Blvd Ste 301 | PO Box 1897
Tahoe City, CA | 530-583-2349
tahoetoothmagic@gmail.com
www.kristenmorgandds.com

KRISTEN J. MORGAN
D.D.S, P.C.

DOCUMENT ACKNOWLEDGEMENT AND CONSENT

PATIENT CONSENT AND AUTHORIZATION
By signing below, you consent to the use and disclosure of your protected health information by Kristen J. Morgan, D.D.S., P.C., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 530-583-2349 and requesting a revised Notice. We will also post any revised notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

INFORMED CONSENT AND AUTHORIZATION
I certify that I have read and understand all eight pages of the INFORMED CONSENT which outlines the general treatment considerations as well as the potential problems and complications of restorative/prosthodontic treatment. I understand that potential complications and problems may include, but are not limited to, those described in this document. I understand that during and following the contemplated procedure, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment.

Recognizing the potential problems and risks of restorative/prosthodontic treatment, authorization given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials, or care if it is felt this time is my best interest. In addition, I consent that photographs and/or videos of the procedures may be shown for teaching purposes.

I HAVE RECEIVED THE HIPPA NOTICE OF PRIVACY PRACTICES DOCUMENT **INITIAL** _____
I HAVE RECEIVED THE DENTAL MATERIALS FACT SHEET DATED MAY 2004, AS REQUIRED BY LAW **INITIAL** _____
I HAVE RECEIVED THE INFORMED CONSENT DOCUMENT **INITIAL** _____

RELEASE OF INFORMATION: I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. The information may be release to:

- ☐ Spouse/Partner _____
- ☐ Children _____
- ☐ Other _____
- ☐ DO NOT RELEASE TO ANYONE _____

PRINTED NAME _____ **SIGNATURE** _____

DATE_____

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FINANCIAL AGREEMENT

I understand that it is my responsibility to know whether or not Kristen J. Morgan, D.D.S., P.C. is a participating provider on my insurance plan and to know my coverage and eligibility status. I understand that my insurance contract is between my insurance company and me, and that Kristen J. Morgan, D.D.S., P.C. is billing my insurance as a courtesy to me. I understand that I am responsible for the balance due on my account. I understand that any co-payment required is due when service is rendered, and if my insurance cannot be verified during my appointment time, I must pay up-front in full, for any materials or services rendered.
INITIAL _____

I understand that if I do not pay my account (or my dependent's account) in full **within 90 days** that my account will be assigned to a collection agency for collections. I understand that if my account is assigned to a collection agency, which will charge a commission or fee that may be as much as **50 percent** of the amount I owe Kristen J. Morgan, D.D.S., P.C. and I agree to pay that additional amount. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I pay court costs and reasonable attorney's fee. **INITIAL** _____

AVAILABLE PAYMENT OPTIONS

- PAYMENT IN FULL
- PRE-PAID PAYMENT PLAN: Payment begins whenever you wish. Patient pays our office in advance, and we run a credit on account. As soon as payments equal the entire amount due for treatment, treatment begins.
- CARECREDIT: 12 month interest deferred options are available. (Upon approved credit). Failure to pay the entire balance within the promotional period will result in a retroactive interest rate of 26.99%
- WE ACCEPT: Cash, Check, Visa, MasterCard, Discover, American Express, HSA Cards, and Care Credit

CANCELLATION AND RESCHEDULING POLICY:

No charge for cancellations or reschedule appointments with more than **48 hours notice**.

Charges for cancelled or rescheduled appointments with less than **48 hour notice** and 'no call, now show' appointments:

$100 per hour with the Hygienist; $150 per hour with Dr. Morgan **INITIAL** _____

*Cancellation due to true medical emergencies, road closure or snowstorm will not incur a charge if our office is promptly notified.

I agree to the above policies, and agree to pay at the time of services as outlined above.

PRINTED NAME_____ **SIGNATURE** _____

DATE_____

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