LASHLEY
FAMILY DENTISTRY

Dr. Craig B. Lashley, D.D.S.
Dr. Alexandra Seltenreich, D.D.S.

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Single ☐Married

First Name_____ M.I._____ Last Name_____ Pref Name:_____

Male/ Female D/O/B_____ SSN_____ Driver's Lic. #_____

Street_____ City_____ State_____ Zip_____

Primary Phone: Home/ Cell_____ Email_____

Employer_____ Bus. Tel.( )_____ Ext:_____ Department:_____

Patient Student Status: ☐Full Time ☐Part Time ☐None School Name_____
(City, State, Zip)

I consent to receive electronic communications between Lashley Family Dentistry and myself at the number and/or email listed above: ☐ **YES** ☐ **NO**

Who will be responsible for this account? ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____
(If self, skip to next section)

First Name_____ Last Name_____ SSN_____ D/O/B_____

Street_____ City_____ State_____ Zip_____

Employer_____ Bus. Tel.( )_____ Alt. Tel.( )_____
☐Full Time ☐Part Time ☐Self ☐Retired

Have you or a **member of your household** been seen in our practice? No Yes, If yes whom?_____

Verbal communication between our office and the individuals named below are allowed:

Name:_____ Relationship:_____ Phone No.:_____
☐ All Dental ☐ Treatment ☐ Billing/ Accounting

Name:_____ Relationship:_____ Phone No.:_____
☐ All Dental ☐ Treatment ☐ Billing/ Accounting

Name:_____ Relationship:_____ Phone No.:_____
☐ All Dental ☐ Treatment ☐ Billing/ Accounting

Primary Dental Insurance Information

Policy Holder's Name_____ D/O/B_____ SSN or ID#_____

Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other ☐Married ☐Divorced ☐Separated ☐Widow ☐Single

Employer Name_____ Policy Group Number_____

Insurance Carrier Name, Address & Tel._____

Insured's Address/ Phone (*if different from above*)_____

Secondary Dental Insurance Information

Policy Holder's Name_____ D/O/B_____ SSN or ID#_____

Employer Name_____ Policy Group Number_____

Insurance Carrier Name, Address & Tel._____

Insured's Address/ Phone *(if different from above)*_____

Person to Contact in Case of Emergency: ***(not within same household)***

Name of Emergency Contact_____ Relationship:_____ Tel. ( )_____

Office Policy and Financial Agreement

Missed Appointment Policy

We expect patients to be present at all scheduled appointments exclusively reserved for them. To avoid a $50 missed appointment / late notice fee, a 48-hour notice is required. This fee must be paid prior to being rescheduled for any missed appointments. After three "No Show" (missed) appointments the patient will be dismissed from our practice.

Late Arrivals

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on our schedule and leads to extra visits for the patient who doesn't arrive at their scheduled time. Late arrivals of greater than 10 minutes risk not being seen. We try to accommodate late appointments as time permits; however, those patients who arrive at their scheduled time will be seen first.

Financial Agreement

As a courtesy to our patients, we will file insurance benefits upon your behalf. ***However, it must be stressed that your insurance is a contract between you, your employer and the insurance company***. Our office will prepare the necessary insurance forms as a courtesy for our patients and accept the assignment of benefit payment from most insurance companies, reducing the immediate out of pocket expenditures. However, **we will collect the estimated portion of your fee at the time that services are rendered, regardless of who accompany the patient on the day of his/her appointment**. Though estimated amounts are collected on the date that services are rendered, any differences that may exist after your insurance company has paid their allowable amount will be billed to you for immediate payment. While we will always attempt to help each patient receive the maximum benefits available, **we will not be involved in disputes between you (the patient) and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc**.

Patients who do not carry dental insurance are responsible for the entire balance of any procedure rendered; due the date of service such procedures are rendered.

Any estimated fee presented for treatment will be extended for a period of 90 days from the date that the treatment estimate is presented, unless prior arrangements or exceptions are approved by our office. Any insurance claims that have not been paid within 60 days will become the guarantor's responsibility, in which you the guarantor will receive notice from our office.

Any outstanding balances will be billed in way of a monthly statement of services, at which remittance is due upon receipt. **Accounts receiving multiple statements may be accessed with a monthly statement fee of $5**. Any account which is sent a third statement with no previous response will be considered a final notice. It is also at the discretion of Lashley Family Dentistry to cancel all scheduled appointments for accounts that are considered past due. All accounts will be considered delinquent after 90 days and placed with an outside third-party company for processing and collection. *The guarantor and/or patient agrees to pay any cost accrued in collecting amounts owing, including court cost, attorneys' fee, collection agency fees and collection cost that is allowable, per state of Kansas law allows of the unpaid debt. Upon this action, the patient and/or their family may be dismissed from our practice, as determined by Lashley Family Dentistry*

For the convenience of our patients, we offer several methods of payment including cash, check, credit card (Visa, MasterCard and Discover), and Care Credit. Any checks returned with insufficient funds will be charged a $30 returned check fee, which must be paid before any future appointments will be scheduled.

I hereby authorize payment of dental benefits otherwise payable to me to be paid directly to Dr. Craig B. Lashley, D.D.S., P.A., Dr. Alexandra Seltenreich, D.D.S., and/or any locum tenens that might be providing treatment. In addition, I acknowledge that I am ultimately responsible for payment. I have read and agree to abide by the policy stated above and acknowledge that failure to comply may result in dismissal from the practice of Lashley Family Dentistry, Dr's. Lashley and Seltenreich, D.D.S.

Signature of Patient, Parent or Guardian | Relationship to Patient | Date

ACKNOLWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign this Acknowledgement**

I, _____acknowledge that I have read a copy of this office's Notice of Privacy Practices and have been supplied with a copy of this Notice of Privacy Practices upon my request.

Signature of Patient, Parent or Guardian | Printed Name/ Relationship | Date