Financial Policy

Kevin N. Schierlinger, D.D.S., P.C.
5895 John R
Troy, MI 48085
(248) 828-8128

This is an agreement between Kevin N. Schierlinger, D.D.S., P.C. as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Kevin N. Schierlinger, D.D.S., P.C.

By executing this agreement, you are agreeing to pay for all services that are received.

Treatment Recommendations: Treatment recommendations are based on your individual needs. Fees are not typically explained prior to rendering treatment. When you accept treatment in our office, you are accepting responsibility for the cost of all services rendered on your behalf or that of your dependents. If you would like to review the fees prior to accepting treatment, please ask to speak to our Financial Coordinator. She will be happy to give you a breakdown of the fees involved.

Payment Policy: Payment for services is due at the time the service is rendered. On treatment requiring multiple appointments, you may choose to pay a minimum of 50% at the initial appointment. The balance may be divided over the remaining appointments and is due in full upon completion. If treatment is suspended or terminated, the remaining balance will become due immediately. We accept cash, checks, and major credit cards.

Credit Policy: In order to extend credit in our office, you give us permission to run a credit report and make other credit inquiries that we determine necessary. With approved credit, we offer a wide variety of both in-office payment arrangements, and third-party interest-free financing. Please ask to speak to our Financial Coordinator with any question regarding your dental investment or to apply for credit.

Insurance: Dental Insurance is a contract between you and your insurance company. We are not party to this contract in most cases. We are happy to file the forms necessary to assure you receive the full benefit of your dental insurance, and we gladly accept direct payment from most insurance companies. However, you are ultimately responsible for all charges that your insurance company does not cover. We will estimate what your insurance company may pay, but we cannot guarantee this coverage. It is the insurance company that makes the final determination of your eligibility and coverage. Therefore, the amount due our office is subject to change once the insurance payment is received. It is important that you understand the full extent of your insurance coverage. If your insurance company does not respond within 60 days, the remaining balance will become your responsibility.

Pre-payment courtesy: For charges exceeding $200.00, a 5% courtesy will be extended for full cash or check payment made prior to the start of treatment.

Senior Citizen Discount: Patients 65 or older are eligible for a 10% discount if payment is received in full on the date of service.

General Discounts: Discounts cannot be combined with any promotional or other courtesy discounts. Discounts will apply only when payment in full is received on the date of service. Discounts may no longer be offered on accounts with a history of poor credit or missed appointments.

The Financial Policy continues on the back side of this page.

Patients Name: ____

Signature of Responsible Party: ______________________________ **Date:** ____________

Monthly Statements: Monthly statements will be sent for any patient balance remaining on your account. The balance on your statement is due by the date shown on the statement. Finance charges will apply if payment is not received by the due date.

Finance Charge: Unless other arrangements have been established in writing, a finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a quarter percent (1.25%) per month or an **ANNUAL PERCENTAGE RATE** of fifteen percent (15%). The finance charge on your account is computed by applying the periodic rate (1.25%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Returned Checks: There is a fee (currently $35.00) for any check returned by the bank. Upon receiving the returned check, our office will attempt to contact the financial institution to verify funds. If funds have become available, we will redeposit the check and bill you for the returned check fee. If funds are still not available, our office will notify you by phone or in writing via certified mail. If the amount due is not paid with cash within seven business days of receipt of notice, it will be considered as intent to defraud and may be reported to the Troy Police Department.

Missed Appointment Fee: The second time a patient does not show up for an appointment, or cancels with less than 24 hour notice, a fee (currently $30.00) may be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past Due Accounts: We will make several attempts to contact you if your account becomes past due. If we are unable to reach you, if you have expressed an unwillingness to pay, or if your balance becomes 120 days overdue, your account will become delinquent. If your account becomes delinquent, we will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau. If collection efforts are required, you shall be liable for all cost of collection, including reasonable attorney's fees. If your account is referred to an outside collection agency, a collection fee will be added to your account. In case of suit, you agree the venue shall be in Oakland County, Michigan.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney, collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, which may include your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, which may include your payment history.

Worker's Compensation, Auto Insurance and Personal Injury Claims: We will gladly process your insurance or lawsuit claim and forward any necessary records as you request, however, payment of the bill remains the patient's responsibility. Payment is expected at the time of service, we will request the insurance carrier send their payment directly to you.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

MEDICAL/DENTAL HISTORY

Medical Alert:

Patient Name

1. Have you been under the care of a medical doctor or been hospitalized during the past five years? ☐ yes ☐ no

   If yes, when and for what reason? ______

   Physician's Name ______ Phone ______

   Address ______ Date of last check-up ______

2. Are you taking any medications, drugs or pills at this time? ☐ yes ☐ no

   If yes, please list ______

3. Are you aware of an allergic or adverse reaction to any medication or substance? ☐ yes ☐ no

   If yes, please list ______

4. Indicate which of the following you have had, or have at present..

Heart (Surgery, Disease, Attack)	☐ yes ☐ no	Ulcers	☐ yes ☐ no	Hepatitis B (Serum)	☐ yes ☐ no
Chest Pain	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Venereal Disease	☐ yes ☐ no
Congenital Heart Disease	☐ yes ☐ no	Thyroid Problems	☐ yes ☐ no	A.I.D.S.	☐ yes ☐ no
Heart Murmur	☐ yes ☐ no	Glaucoma	☐ yes ☐ no	H.I.V. Positive	☐ yes ☐ no
High Blood Pressure	☐ yes ☐ no	Contact Lenses	☐ yes ☐ no	Canker Sores/Fever Blisters	☐ yes ☐ no
Mitral Valve Prolapse	☐ yes ☐ no	Emphysema	☐ yes ☐ no	Blood Transfusion	☐ yes ☐ no
Artifical Heart Valve	☐ yes ☐ no	Chronic Cough	☐ yes ☐ no	Hemophilia	☐ yes ☐ no
Heart Pacemaker	☐ yes ☐ no	Tuberculoses	☐ yes ☐ no	Sickle Cell Disease	☐ yes ☐ no
Rheumatic Fever	☐ yes ☐ no	Asthma	☐ yes ☐ no	Bruise Easily	☐ yes ☐ no
Arthritis/Rheumatism	☐ yes ☐ no	Hay Fever	☐ yes ☐ no	Liver Disease	☐ yes ☐ no
Cortisone Medicine	☐ yes ☐ no	Allergies or Hives	☐ yes ☐ no	Yellow Jaundice	☐ yes ☐ no
Swollen Ankles	☐ yes ☐ no	Sinus Trouble	☐ yes ☐ no	Neurological Disorders	☐ yes ☐ no
Stroke	☐ yes ☐ no	Radiation Therapy	☐ yes ☐ no	Epilepsy or Seizures	☐ yes ☐ no
Diet (Special/Restricted)	☐ yes ☐ no	Chemotherapy	☐ yes ☐ no	Fainting or Dizzy Spells	☐ yes ☐ no
Artificial Joints (hip, knee,etc.)	☐ yes ☐ no	Tumors	☐ yes ☐ no	Nervous/Anxious	☐ yes ☐ no
Kidney Trouble	☐ yes ☐ no	Hepatitis A (infectious)	☐ yes ☐ no	Psychiatic/Psychological Care	☐ yes ☐ no

5. Do you have or have you had any disease, condition, or problem not listed? ☐ yes ☐ no

   If yes, please list: ______

6. Women. Are you: Pregnant? ☐ yes, _____ Months ☐ no Nursing? ☐ yes ☐ no Taking birth control pills? ☐ yes ☐ no

7. What is the reason for your visit today? ______

8. Date of last Dental visit ______ Date of Last Dental cleaning ______

   Previous Dentist's name ______ Address ______

9. Are your teeth sensitive to:
   - Hot/cold ☐ yes ☐ no
   - Sweets ☐ yes ☐ no
   - Chewing ☐ yes ☐ no

10. Have you experienced:
    - Clicking or popping of the jaw ☐ yes ☐ no
    - Difficulty opening or closing mouth ☐ yes ☐ no
    - Pain (joint, ear, side of face) ☐ yes ☐ no

11. Do your gums bleed or hurt? ☐ yes ☐ no

12. Are you satisfied with the appearance of your teeth? ☐ yes ☐ no

13. Would you like to keep all your teeth all your life? ☐ yes ☐ no

14. Do you feel nervous about having dental treatment? ☐ yes ☐ no
    If so what is your biggest concern?
    ______

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ______ Date ______

Doctors Comments: ______

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

START HERE IF THIS APPOINTMENT IS FOR YOU

DATE			1
NAME			
SPOUSE			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

START HERE IF THIS APPOINTMENT IS FOR YOUR CHILD

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE

IF YOUR CHILD'S NAME AND /OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

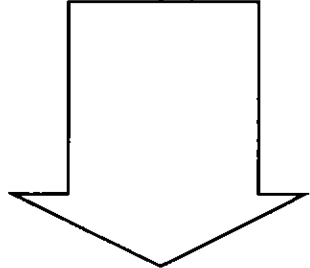
DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE COMPANY
EMPLOYER
EMPLOYEE
DATE OF BIRTH
GROUP NO.
DATE EMPLOYED
EMP. SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY
EMPLOYER
EMPLOYEE
DATE OF BIRTH
GROUP NO.
DATE EMPLOYED
EMP. SOCIAL SECURITY NO.



GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE?

THEIR NAME: RELATIONSHIP:

REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT	DRIVERS LICENSE NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.	SOCIAL SECURITY NO.	

YOU

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NO.	EXT.

YOUR SPOUSE

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NO.	EXT.

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor-to make a thorough diagnosis of

   (name of patient) ____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (15% APR) may be added to my account.

Please be advised that even though there may be Dental Insurance coverage, the ultimate financial responsibility is that of the patient or parent in situation regarding dependents. Dental Insurance is a benefit to you from your employer. There are contractual limitations between your employer and most Dental Insurance carriers, of which we are not liable. Please inform yourself of the full extent of your insurance coverage. We will be happy to explain but will not guarantee this coverage.

Patient ______________________________ Date ____________ Witness ______________________________

Parent or Responsible Party ______________________________ Relationship to Patient ______________

Symptoms of Temporomandibular Dysfunction

The jaw joints, called the temporomandibular joints or "TMJ", are among the most complex joints in the body. They are the only joints which must be in complete harmony with each other in order to work properly. When this complex system of muscles, ligaments, discs and bones do not work properly together, it could result in a condition known as TMD, for Temporomandibular Dysfunction. Following is a list of symptoms which could be related to the jaw muscles and joints. Experiencing any of these symptoms could be a sign of TMD. Many patients experience symptoms, yet have no apparent loss of function. However, sometimes the symptoms slowly get worse and require treatment. Awareness of these symptoms in early stages is also important in diagnosing the cause of other dental conditions such as fractured teeth or bone loss. Monitoring symptoms is the only way to properly diagnose TMD. Please indicate if you have experienced any of the following symptoms. We will continue to monitor at future appointments.

Patient Symptoms:

Symptom	Date:	Symptom	Date:
❑ Pain in the jaw muscles	______	❑ Sensitivity to sound	______
❑ Facial muscles feel tight constantly (face feels tired)	______	❑ Recent loss of hearing	______
❑ Frequent headaches	______	❑ Pain behind the eye	______
❑ Pain in one or both jaw joints	______	❑ Light sensitivity	______
❑ Clicking, grating or cracking sound in one or both jaw joints	______	❑ Excessive tearing	______
❑ Limited opening with or without pain	______	❑ Blurred vision	______
❑ Inability to find a consistent bite	______	❑ Difficulty swallowing	______
❑ Lower jaw locks closed or open	______	❑ Pain in tongue, cheek, or lip	______
❑ Difficulty chewing	______	❑ Chronic mouth breathing	______
❑ Inability to open or close smoothly	______	❑ Snoring	______
❑ Teeth tender to pressure/chewing	______	❑ Sleep apnea	______
❑ Sensitivity to temperature	______	❑ Crowded upper and/or lower teeth	______
❑ Teeth grinding	______	❑ Scalloped tongue	______
❑ Numbness in any area of the face/neck	______	❑ Tongue chewing	______
❑ Unexplained tooth pain	______	❑ Fullness in one or both ears	______
❑ Clenching	______	❑ Ear pain	______
		❑ Dizziness	______
		❑ Ringing in ear	______
		❑ Buzzing of ears	______

Doctor Findings:

Finding	Date	Finding	Date
❑ Abfractions, bone loss, gum recession	______	❑ Cervical erosion	______
❑ Open contacts with no periodontal rational	______	❑ Opening/closing lateral deviation of lower jaw	______
❑ Anterior and/or posterior wear facets	______	❑ Depressed curve of Spee	______
❑ Tilted teeth (mostly lingual inclination)	______	❑ Bicuspid drop off	______
❑ Premature occlusal or incisal tooth contact	______	❑ Fractured teeth or restorations	______
		❑ Lack of posterior support	______
		❑ Torus mandibularis	______
		❑ Decrease in opening measurement	______

OPENING MEASUREMENT ______

Notes:

____

____

____
Patient Name (printed)

____ ______________
Patient Signature Date

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

______________________________ Patient Signature

______________________________ Patient Name (please print)

Date: __________________________

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

____

An emergency situation prevented the patient from signing the Acknowledgement.

______________________________ Office Personnel (signature)

______________________________ Office Personnel (print name)

Date: __________________________

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

______________________________ Patient Signature

______________________________ Patient Name (please print)

Date: __________________________