

7518 Hwy 70 S, Ste B
Nashville, TN 37221
(615) 669-2780



7186 Nolensville Rd, Ste B
Nolensville, TN 37135
(615) 669-5485

Patient Registration Form

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____ Birthdate: _____ Email: _____

Employer: _____ Work Phone: _____

Check One: Minor Single Married Other

Patient Emergency Contact Information

Name _____ Relationship: _____ Phone: _____

Responsible Party (If under the age of 18)

Name: _____ Relationship to Patient: _____

Address: _____ Birthdate: _____

Phone: _____ Employer: _____

Office Payment Policy

As a courtesy we will submit dental insurance, but we cannot accept the responsibility for collecting insurance payments or for negotiating a dispute claim. Insurance is a contract between the patient and the insurance carrier. Even though you may be covered by dental insurance, there will be a co-pay due on the day of your visit. You can expect either an overpayment refund or a bill for the uncovered portion of the insurance payment after our office has received it, since it is not possible to predict the exact amount of the insurance payment prior to the initiation of treatment. Please initial here that you have read and understand this policy _____

The best doctor-patient relationships are maintained when there is complete understanding of the treatment rendered and the fee. Please initial here that you have read and understand this policy _____

For convenience we offer the following methods of payment: Please check your intended method of payment:

Credit/Debit Card

Personal Check

Cash

CareCredit

DENTAL INSURANCE (Please inform the front desk if you have secondary dental insurance)

Subscriber Name : _____ Relationship to patient: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ Phone Number: _____

Group Number : _____ Subscriber ID Number: _____

Insurance Company Address: _____

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Release of Information

I authorize release of any information relating to this insurance claim. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I authorize and request my dental insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Consent for Use and Disclosure of Health Information: We take our patients' health information privacy seriously, and we will make every effort to protect that information. It is our policy that we only disclose patient health information about treatment, payment, and healthcare operations. Any other disclosure of healthcare information would require a written authorization except for communication to the referring general dentist or other medical/dental specialist directly involved in your treatment.

Signature of Patient, Parent, or Guardian

Date

You may refuse to sign this acknowledgment

May we leave a voicemail message for you on your personal phone with information regarding billing, treatment estimates, and upcoming appointments? Yes / No

May we leave messages concerning your appointment/treatment with a co-worker or receptionist? Yes / No

Please list family/friends below that we may discuss your appointment/treatment with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient, Parent, or Guardian

Date

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Patient Medical History

Date: _____ Referring Dentist: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Gender: Male / Female

List All Current Medications (Prescribed and OTC): _____

List All Drug Allergies (Medications, Environmental, Foods): _____

Are you allergic or sensitive to latex or rubber gloves? YES NO

Have you ever had an adverse reaction to local anesthetic? YES NO

Have you ever had any excessive bleeding requiring special treatment? YES NO

Circle any of the following, which you have had or currently have:

- | | | | |
|--------------------|--------------------------|---------------------|-----------------------|
| AIDs | Cold Sores | Heart Attack | Mitral Valve Prolapse |
| Allergies or Hives | Colitis | Heart Murmur | Pain in Jaw |
| Anemia | Cortisone Medications | Hemophilia Dru | Psychiatric Treatment |
| Angina Pectoris | Diabetes Type I | Drug Addiction | Radiation Therapy |
| Arthritis | Diabetes Type II | Hepatitis – Type___ | Rheumatic Fever |
| Artificial Joint | Emphysema | High Blood Pressure | Sinus Troubles |
| Asthma | Epilepsy or Seizures | HIV | Stroke |
| Blood Transfusion | Fainting or Dizzy Spells | Kidney Issues | Thyroid Disease |
| Cancer | Glaucoma | Liver Disease | Ulcers |
| Chemotherapy | Hay Fever | Migraines | Venereal Disease |

Do you have any disease or condition not listed? _____

WOMEN: Are you pregnant: YES NO If so, how many weeks? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the office without fail.

Signature of Patient, Parent, or Guardian

Date

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, Elite Endodontics, to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payer (e.g. my insurance company);
- The day-to-day healthcare operations of Elite Endodontics healthcare practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient/ Legal Guardian Printed Name: _____

Patient/ Legal Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Financial Policy

Thank you for considering Elite Endodontics for your treatment. We pride ourselves in transparent patient-centered care. If at any time you have any questions, please feel free to ask one of our team members, so that we may better serve you. All recommended treatments are in the best interest of our patients. We will assist you in your payment options to help you receive the highest quality of dental care treatment that is necessary for your needs.

Dental Insurance

We estimated insurance benefits as a courtesy to our patients. Please note that your dental insurance is a contract between you and your insurance company. Our office will submit insurance claims as a courtesy to the patient (unless otherwise noted). The ultimate responsibility for understanding ones insurance policy belongs to the patient. This includes, but is not limited to, understanding your maximum yearly/lifetime benefits (if applicable), deductibles, and co-pay coverage. Our usual and customary fees, which are based on geographical area, are a reflection of our commitment to excellence. All estimated co-pays and deductibles are due at the time of service.

For any patient with dual insurance: despite verifying benefits, dual insurance is difficult to estimate for without a predetermination from both insurance companies, which can take 6-8 weeks. If you have dual insurance, we will estimate and collect from you on the date of service based on your primary benefits. We will submit your claim to both primary and secondary insurance policies and refund you upon receipt of all insurance payments if an overpayment is made. If you wish to have a predetermination completed, please request this prior to beginning treatment and be aware this can take several weeks depending on the insurance companies involved.

Balances remaining after 60 days will be charged 12.5% APR until the balance is paid in full.

In the event that insurance does not cover your treatment or is cancelled/terminated for any reason, or cannot be verified for any reason, the patient or responsible party will be responsible for the entire fee amount including the insurance portion.

Emergency Patients

Please note that our policy required verification of insurance. In the event that we are not able to verify your insurance information, payment will be due at the time of service. We will assist you in submitting a claim to your insurance company, so that the insurance company will reimburse you directly for your treatment. If the insurance payment is sent to our dental center, any applicable credit will be refunded to the patient.

Treatment Changes

Due to the uncertainty of some teeth and cases, we occasionally have to include additional treatment modalities. This includes D3221 debridement, D3331 obstruction/ calcification, or D3351 initial visit, placement of medication inside the tooth. These codes will be billed to insurance, but the balance will be your responsibility.

Possible complications may present during treatment that would render the prognosis unfavorable including fractures or cracks that could not be indentified until treatment has been initiated. In these cases, patients will be made aware of the findings and treatment will be downgraded to incomplete endodontic therapy. Incomplete Endodontic Therapy is not covered by most dental insurances and patient is responsible for the \$600 fee.

Appointments Cancellation Policy

We reserve appointment times especially for you and your dental care needs. We strive to give each patient a courtesy call one to two days in advance of their scheduled visit. However, you are expected to keep your appointment time with or without our courtesy call. Therefore, we ask kindly ask that you give 24-hour notice if you are unable to keep your appointment. Please note that if 24-hour notice is not given, there may be a \$75 broken appointment fee. A broken appointment is a loss to yourself, your dentist, and to another patient who could have had that appointment time. We reserve the right to terminate your relationship with our office after 2 (two) or more broken appointments without 24-hour notice.

Patient Identification

We require a picture I.D. for all patients over the age of 18. We also require permission for treatment from a patients guardian if under 18 years of age.

Method of Payment

Cash, ATM/Check cards and all Major Credit Cards

Cash and Checks: (with proper I.D.). There will be a fifty dollar (\$50) returned check fee applied to your account in the event your check is denied by the bank. Payment will be expected within 48 hours of notice from the bank, in cash or by credit card.

Major Credit Cards: (American Express, MasterCard, Vise, Discover) all credit card will be subject to a processing fee of 3% of the total amount charged. This fee will be added to the transaction total at the time of payment to cover the costs imposed by the credit card processing service. By choosing to pay by credit card, patient acknowledges and agrees to this additional charge.

Third Party: As an added courtesy, we also offer a revolving line of credit through a third party (upon credit approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time. Please Note: Third party fees can be applied back to your account.

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*Our fees and estimated patient portions are explained and disclosed prior to receiving any treatment plan or services. Our fees are reasonable and commensurate with the knowledge, skill, experience and service provided by our dentist and staff.

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In the event that a patient's payment plan is established and their card fails to process, an extra charge will be applied to the patient's account to cover transaction fees.

Deposit

We may require a deposit be made to hold any appointment time.

Refund Policy

1. Once Services are performed, refunds cannot be made for those services.
2. A Release of Claims form must be signed before refunds are issued.
3. Any overpayment after insurance claim is closed will be refunded within sixty (60) business days.
 - Refunds will be sent to the address patient provided. For any additional changes, patient is responsible for any fees that are accrued.

Agreement to Pay

In the event there is a default of payment on any balance due, Elite Endodontics will make all necessary collection efforts to secure the balance due. This may include reporting a delinquency to a credit report agency and taking legal action. Any additional costs incurred will be charged to the patient or responsible party, this includes but is not limited to the additional percentage collected by the collection agency, any legal fees, court costs, etc.

By signing for, and accepting this policy, I understand that I am entering into a contractual relationship with Elite Endodontics for professional care and that I am financially responsible regardless of payment and/or denial of my insurance claims(s) by my insurance company. I further understand that it is my responsibility to understand my insurance yearly/lifetime benefit maximum (if applicable), deductibles, and co-pay coverage and that Elite Endodontics will submit my claims as courtesy, but I am ultimately responsible for all fees incurred for my treatment if insurance does not remit payment/pays differently than what is provided on my treatment plan estimate.

I have read, understand, and agree to all stated within the Financial Agreement.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

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Acknowledge Information is True and Correct

The medical information I have provided is complete. I do not hold any staff member in this office responsible for any errors or omissions that I may have made in the completion of this information.

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Patient Signature: _____ Date: _____

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PROCEDURE WAIVER AND FEE NOTICE

Elite Endodontics is pleased to announce that we now offer the **GentleWave® Procedure**. This advanced treatment enhances root canal cleaning and disinfection through a minimally invasive protocol designed to reduce postoperative discomfort and promote faster healing. It dissolves organic tissue up to 7x faster than conventional devices, even cleaning microscopic spaces that can't be reached by standard root canal treatment.

Dr. _____, a Board-Certified Endodontist, will first evaluate whether you are a suitable candidate for the GentleWave Procedure by reviewing your clinical eligibility. If your case qualifies, Dr. Dyriw and our staff will provide you with detailed information regarding the procedure.

Please note that the GentleWave Procedure does not have a specific billing code recognized by the **American Dental Association (ADA)**. Because of this, the procedure will **not** be submitted to your dental insurance. The fee for the single-use hand piece and disposables used to perform the GentleWave procedure is **\$120.00** and will be your responsibility, due at the time of service.

What You Should Do:

Carefully read this notice to make an informed decision about your care.

Ask any questions you may have before signing.

I, _____, have read and understand this notice, as indicated by my signature below.

Signature: _____ Date: _____

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Patient Consent Form for Endodontic (Root Canal) Therapy

I consent to the administration of such anesthetics and other medications as may be considered necessary or advisable by the dentist responsible for this service. I have fully informed the dentist of all recent and current medication and drugs and all known drug and food allergies.

I understand the following:

- The goal of this treatment is to retain function of the tooth or teeth treated.
- During the course of treatment, a minimal number of x-rays will be needed.
- Treatment may require multiple visits and it is important to maintain scheduled appointments.
- It may be necessary to alter the tooth or remove a restoration (filling or crown) from the tooth being treated
- Proper post-treatment restorations of the tooth is necessary. I **must** contact my referring dentist soon after completion of this endodontic treatment to arrange final treatment.
- Possible complications may include but are not limited to: swelling, discomfort, injury to adjacent teeth, continued or new infection, numbness of lip, chin, tongue, or gums, fracture to the tooth and subsequent loss of the tooth, poor healing, bleeding, separation of working instruments within the tooth, root perforations, or extraction.
- Possible complications from anesthetics are numerous but very rare include but are not limited to allergic reaction, cardiac and/or respiratory attack, choking, aspiration from vomiting and infection.
- The benefits of this procedure is maintenance of a diseased tooth that would otherwise be extracted.
- The fee associated with treatment does not include any follow-up surgical procedures which may be necessary in a small number of cases.
- The alternative is partial or complete tooth removal.

The nature and purpose of the processed, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained from treatment. I give permission to Elite Endodontics to record or take digital photos of the treatment for purposes of completing my medical record and/or for patient education.

All of my questions have been answered by Dr. _____, and I fully understand the above statements in this consent form.

Patient Printed Name: _____

Patient Signature: _____ Date: _____