Please print clearly

Patient Name_____ Patient Social Security No._____

Address_____ City_____

State_____ Zip_____ Phone_____ Work/Cell Phone _____

Email Address_____ Employer _____

Dental Insurance _____

Spouse's Name_____ Date of Birth_____

Place of Employment_____ Social Security No._____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff of Hannahan Endodontic Group to perform any necessary dental services during diagnosis and treatment. A copy of our Notice of Privacy Practices is available in our waiting area. I also authorize Hannahan Endodontic Group and/or our agents to contact me by phone, cell phone, "Text Message," Email or any other universally used modes of communications as needed to confirm appointments, provide essential treatment information or secure payment of outstanding past due balances. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Signature:_____ Date: _____

OUR PAYMENT POLICY

Patients who have dental coverage are responsible for the **ENTIRE ESTIMATED COPAY** at the first visit. If you do not have insurance, it is our policy that $^1/_2$ payment be made the first visit and the remaining $^1/_2$ of the total be paid at the second visit. If all work is completed in one visit, **total** payment is required.
I/We agree that if the balance becomes delinquent, defined as 90 days past due, and is referred to a collection or attorney, we shall be responsible for collection agency fees equal to 33 $^1/_3$% of the balance due in addition to the principal balance. We further understand and agree that if legal action is taken to collect the balance, we shall also be responsible for all court cost. We hereby waive our rights under the laws and constitution of Alabama, or any other state, to exempt our real or personal property from execution. INSURANCE AUTHORIZATION: I hereby authorize Hannahan Endodontic Group to furnish treatment information to insurance carriers to facilitate the processing of my insurance claim. I do hereby assign to Hannahan Endodontic Group all payments for dental services rendered to myself or my dependent. The filing of your insurance claim is a courtesy that we extend to you, all charges are ultimately your responsibility.

Please check ❑ **Patient understands that copay quoted is only an estimate and will be billed for the difference.**

Signature:_____ Date: _____