GREAT PLAINS
ORAL & MAXILLOFACIAL SURGERY, PA

PATIENT INFORMATION

PATIENT LEGAL NAME:____**NICKNAME:**______________
First Middle Last

Physical Address: ____
Number & Street City State Zip Code

Postal Address (if applicable):____
Number & Street City State Zip Code

Marital Status: S M W D Birth Date:____________Age:_____Sex:___Social Security#________________

School:______________________________ Full-time: Part-time:

Employer:____________________________ Full-time: Part-time: Occupation:_____________________

Home Ph:(____)______________Cell Ph:(____)______________Work Ph:(____)______________E-mail:____________

PHYSICIANS (full names please):

Referred by:__________________________________ Medical Doctor:__________________________________

General Dentist:______________________________ Other:____

INFORMATION ABOUT YOUR: SPOUSE (SIGNIFICANT OTHER) GUARDIAN/PARENT

Name:____________________________ Birth Date:____________Social Security#:______________ Marital Status:_____

Physical Address (if different from patient):____
Number & Street City State Zip Code

Employer:____ Occupation:______________________________

Home Ph:(____)______________Cell Ph:(____)______________Work Ph:(____)______________E-mail:____________

PERSON RESPONSIBLE FOR ACCOUNT: Self Other If other, specify relationship to patient:________________
Name (if different from patient):____________________Birth Date:__________ Social Security#:__________________
Physical Address:____
Number & Street City State Zip Code

Postal Address (if applicable):____
Number & Street City State Zip Code

Employer:____________________________________Occupation:_______________________________________

Home Ph:(____)______________Cell Ph:(____)______________Work Ph:(____)______________E-mail:____________

965 N. Murlen Road, Olathe, KS 66062 | 913.780.3100 | www.gpoms.com

EMERGENCY CONTACT: Relative or Close Friend

Name:____________________________ Relationship to Patient:____________________________

Home Ph:(____)______________ Cell Ph:(____)______________ Work Ph:(____)______________ E-mail:______________

DENTAL INSURANCE: ***IN ORDER FOR CLAIM TO BE FILED ALL DATA IN THIS SECTION MUST BE COMPLETED IF NOT ON INSURANCE CARD.***

Insurance:______________________ Phone #:______________________ Insured:______________________

Birth Date:__________________ Relation to Patient:________________ Social Security #:______________________

ID#:______________ Employer Group Name:______________________ Group #:______________________

Address to file claims:________________________________ City:______________ State:_____ Zip:________

MEDICAL INSURANCE: ***IN ORDER FOR CLAIM TO BE FILED ALL DATA IN THIS SECTION MUST BE COMPLETED IF NOT ON INSURANCE CARD.***

Insurance:______________________ Phone #:______________________ Insured:______________________

Birth Date:__________________ Relation to Patient:________________ Social Security #:______________________

ID#:______________ Employer Group Name:______________________ Group #:______________________

Address to file claims:________________________________ City:______________ State:_____ Zip:________

SECONDARY INSURANCE: Dental Yes No Name:________________________________
Medical Yes No Name:________________________________

1. INSURANCE:

   Great Plains OMS, PA is a provider with many dental insurance programs. Please contact our business staff to verify your eligibility. If the doctor is a participating provider, we will file insurance claims as a courtesy and accept your insurance company's "allowable" payment. We will estimate these charges for you shortly after your consultation, and these charges must be paid prior to treatment or surgery. After payment is received from insurance, we may owe you a refund, or you may owe additional sums not covered by insurance.

   We will supply factual information necessary to process your claim(s); however, we will not become involved in disputes between you and your insurance company regarding claims, deductibles, covered charges, co-payments, discounts, secondary insurance, "usual and customary" charges and other insurance issues.

   We are NOT participating providers with Medicare, Medicaid, or any medical insurance. **We require payment in full on the day of surgery for patients with these insurance carriers.**

2. PAYMENT OPTIONS AND FINANCING:

   Great Plains OMS, PA gladly accepts payment via cash, check, Visa, Mastercard, or Discover. We reserve the right to confirm funds with your bank, for any amount over one hundred dollars ($100). If you are in need of an extended finance option, we work with Care Credit. Please feel free to contact our office for information and application instructions.

For those patients that Great Plains OMS, PA is not accepting an insurance write-off, a courtesy discount of 5% is given for cash or check payment-in-full at the time services are rendered. A minimum of $250 dollars of services rendered is required to qualify for this discount.

3. FINANCIAL AGREEMENT:

I agree that in return for the services provided to the patient by Great Plains OMS, PA, I will pay any amount my insurance does not cover, including deductibles and co-payments prior to the time service is rendered. I authorize and hereby request my insurance company to pay directly to Great Plains OMS, PA insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. **I UNDERSTAND THAT ANY REMAINING BALANCE, 60 DAYS AFTER DATE OF SERVICE REGARDLESS OF INSURANCE STATUS IS MY RESPONSIBILITY.** I agree to be responsible for payment of all services rendered on my behalf or my dependents, on accounts that have not been satisfied by insurance, patient, or guarantor.

If my account is sent to a collection agency, I agree to pay all reasonable collection expenses, court costs, and attorney fees. I agree to pay interest on all past due accounts at the maximum rate allowed by law. I further agree that if a lawsuit is required to collect my account, the suit will be filed in Johnson County District Court or any other Court deemed necessary at the sole discretion of Great Plains OMS, PA or its attorney.

4. **RELEASE OF INFORMATION:**

In accordance with its **Notice of Privacy Practices**, Great Plains OMS, PA may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation 1) which is or may be liable or under contract to Great Plains OMS, PA or reimbursement for services rendered; 2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original; 3) persons as indicated by patient

______________________,	______________________,	______________________,
Name 1	Name 2	Name 3

AUTHORIZATION, RELEASE, & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the doctor and other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize the taking of photos, radiographs, and other diagnostic records before, during, and after treatment. I authorize Great Plains OMS, PA to release any information (via mail, fax, or electronic) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such dental/medical care to third party payors and other entities and/or health practitioners. HIPAA Notice of Privacy Practices has been made available to patient and/or guarantor.

______________________	______________________	______________________
Signature of Patient	OR Signature of Guardian	Date

Printed name of patient/guardian as signed above ______________________________

This copy of signature is valid as the original. Signature on file is valid indefinitely.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date:

I, ________________________, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_________________________________ _________________________________

Name Date