Dr. Wade Larson ● Dr. Brendan Green
2707 North 400 East, No. Ogden, Utah 84414
(801) 782-0866 benlomonddental@gmail.com

RESPONSIBLE PARTY:

(person receiving billing statement, and responsible for dependent under age 18)

First Name: ______________ Last Name: ______________ MI: ______

Address: ______________ Apt #: ______

City: ______________ State: ______ Zip Code: ______

Home Phn: ______________ Work Phn: ______________ Cell Phn: ______________

Sex: ☐ M ☐ F Birthdate: ________/________/________ SSN: ________-________-________ Marital Status: ______________

Who may we thank for referring you to our office? ☐ phonebook ☐ internet ☐ doctor ☐ other (name) ______________

PRIMARY DENTAL INSURANCE

Ins. Co.: ______________

Ins. Addr: ______________

Phone #: ______________ Group #: ______

Eff Date: ______ ID#: ______________

Employer: ______________

Subscriber: ______________

Address: ______________

____
City State Zip

Birthdate: _______/_______/_______ SSN: ______-______-______

Relationship to Responsible Party:

☐ Self ☐ Spouse ☐ Parent ☐ Step-Parent

SECONDARY DENTAL INSURANCE

Ins. Co.: ______________

Ins. Addr: ______________

Phone #: ______________ Group #: ______

Eff Date: ______ ID#: ______________

Employer: ______________

Subscriber: ______________

Address: ______________

____
City State Zip

Birthdate: _______/_______/_______ SSN: ______-______-______

Relationship to Responsible Party:

☐ Self ☐ Spouse ☐ Parent ☐ Step-Parent

DEPENDANTS INSURANCE COVERAGE

NAME	PRIMARY INSURANCE	SECONDARY INSURANCE	RELATIONSHIP

APPOINTMENT REMINDERS

We are now sending appointment reminders via email and/or text message. Please provide us with the requested information for yourself/spouse/partner:

______________ Responsible Party Email

______________ Responsible Party Cell Phone

______________ Spouse/Partner Email

______________ Spouse/Partner Cell Phone

☐ I would prefer not to receive appointment reminders by email or text message. (If checked, you will receive a courtesy phone call reminder)

Office Financial Policy

We are committed to providing you with the best possible care and to keep costs as reasonable as possible. In order to achieve these goals, we need your assistance, and your understanding of our financial policy.

Payment for service is due at the time services are rendered. We accept cash, checks, VISA, MASTERCARD, Discover, American Express and Care Credit. Also, upon approval, we will accept payments by arranging for payment using your VISA, MASTERCARD, Discover or American Express.

As a benefit to you, we will be happy to submit your dental claims to your insurance carrier on your behalf. However, please remember:
1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract. 2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to a maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." (Usual, customary and reasonable) fees. 3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

As dental care providers, our relationship is with you and not your insurance company. As a courtesy to our patients, we try to assist in the filing of insurance claims. However, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems can occur. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks and balances older than 90 days may be subject to additional collection fees and interest charges of one and one-half percent per month. Charges may also be made for broken appointments and appointments cancelled without forty-eight (48 hour) hours advance notice. We also reserve the right to run a credit check any time that the balance will not be paid in full at the time of service.

I also hereby agree to assign all dental and/or surgical benefits, to include major dental benefits to which I am entitled, including private insurance, our in-house insurance plan, and any other health plans to Ben Lomond Dental.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you. Our office manager will be happy to assist you in any way possible.

Agreement for Extension of Credit & Release Form

I have read and understand the financial policy of the Ben Lomond Dental. In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to this office:

The responsible party agrees to the following:

1. To pay the doctor at time the treatment or service is rendered, or by previous arrangements.
2. That if payments are extended beyond 90 days from the date of the first billing, to pay 1 ½% per month interest on the unpaid balance (annual rate of 18%).
3. In the event the account is turned over for collection, the collection fee of 40% and legal fees, including attorney fees and court costs shall be my responsibility.

** I authorize release of any information regarding my dental treatment, appointments and financial information to:

____

(Parent, spouse, legal guardian or other authorized agent of patient)

Signature: ____ Date: ______/______/______

Witness: ____ Date: ______/______/______