Darren W. Sinopoli, DMD

FINANCIAL & INSURANCE POLICIES

Thank you for entrusting us to care for your dental health. As part of our services, we make every effort to keep down the cost of healthcare. In an effort to do so, we ask that you read the following office policies prior to treatment.

If you need additional information or explanation, we will be happy to assist you. Thank you for your cooperation.

Our policy is to request payment at the time of your visit as the cost of billing statements, and billing staff affects fees.

INSURANCE CO-PAYS, PERCENTAGES AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICES

Cash, personal checks, VISA, MasterCard, American Express, Discover and Care Credit are accepted.

Read/Initial All:

_____ **Dental Insurance**
Insurance is billed as a courtesy to our patients, and the patient is the final responsible party. If your insurance has not paid the claim within 60 days, you will be notified and billed for the balance due. Most insurance companies will not cover 100% of all dental expenses.
We are an IN-NETWORK provider for the following Insurances: AETNA, AMERITAS, ASSURANT PPO, BC/BS WELMARK, CIGNA, COMPBENEFITS PPO, DELTA CARE, DELTA DENTAL, DENTEMAX, FL COMBINED – BC/BS PPO, GUARDIAN, METLIFE, PRINCIPAL, and UNITED HEALTHCARE

Please understand that this office is an OUT-OF-NETWORK provider (or Non-participating) for ALL other insurance companies. Services will be paid at a "Usual & Customary Rate" and the patient will be responsible for any remaining balance. Also, understand that Dental Insurance is a contract between the patient and the Insurance Company, not a contract between the Insurance Company and our Office.

_____ **Non-Insurance**
Full payment is due at the time services are rendered unless arrangements have been made.

_____ **Collections**
This office does utilize a collection agency, if necessary, for collecting outstanding balances. The office will make efforts to collect the balance, but at a certain times, a collection agency will be utilized. The patient will be responsible for the outstanding balance and any fees incurred from the collection agency.

I have read, agree, and understand the above.

_____ _____
Patient/Parent or Responsible Party Date

Patient Medical History

Date of Birth _____ SS#_____ Today's Date_____

Name _____
Last First Middle

Address_____
City State Zip

_____
Home Phone Cell Phone Work Phone

_____
Email Address

Spouses Name and Phone # (parent if minor) _____ # _____

Name of your insurance company? _____

Is Insurance Under: Parent _____ Spouse _____ Other _____

INSURANCE POLICY HOLDERS INFORMATION

Name _____

Social Security # or ID # _____ Date of Birth _____

Employers Name _____ Employers Phone _____

Employers Address _____

Insurance Authorization: I hereby authorize Darren W Sinopoli, DMD, to furnish copies of my records to my insurance company upon request. I hereby assign to Darren W Sinopoli, DMD, all payments for dental services rendered to myself or my dependent. A copy of this signature is as valid as the original. I agree to be responsible for any co-pays, deductible and/or any charges not covered by my insurance.

_____ _____
Signature Please Print Name

Please Circle EACH Condition that Pertains to You, Previously or Currently
Your answers are for our records ONLY and will be considered Confidential.

AIDS/HIV	Epilepsy	Joint Replacement	Rheumatic Fever
Angina	Heart Attack	Kidney Disease	Sinus Problems
Arrhythmia	Herpes	Liver Disease	Stomach Problems
Asthma	Heart Murmur	Mitral Valve Prolapse	Stroke
Cancer	Hepatitis	Other Heart Condition	Substance Abuse
Chest Surgery	High Blood Pressure	Pace Maker	Thyroid Disease
Diabetes	Depression	Pregnant/Nursing	Tuberculosis

Other conditions not listed above? _____
Medications presently taking? _____
Allergic to ANY drugs? (please list) _____
Do you require Premedication with antibiotics prior to dental treatment? _____
Any conditions relevant to your visit today? _____

_____ _____
Patient Signature (I certify the above medical information is correct) Date

ENDODONTICS
265 Hatteras Ave.
Clermont, Fl. 34711
Phone: 352-394-0150

Notice of Privacy Practices Patient Acknowledgement

Patient Name:_____Date of Birth_____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice Includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions or certain uses and disclosures of my protected heath information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected heath information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice Of Privacy Practices from the this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____Date:_____

Relationship to patient (if signed by a personal representative of patient_____

Clermont
Endodontic
Specialist

265 Hatteras Ave.
Clermont, Fl. 34711
Phone: 352-394-0150
Fax: 352-243-0654

ENDODONTIC CONSENT AND INFORMATION SHEET

Endodontics, or root canal therapy, is that specialty of dentistry devoted to the saving of the teeth in which the pulp or nerves are affected. It is true that it is easier to extract a tooth than to save it, but the value of a natural tooth is irreplaceable. In addition, extraction and replacement is usually more expensive.

We would like our patients to be informed about the various procedures involved in Endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conventional root canal therapy, or when needed, Endodontic surgery. The following discusses possible risks that might occur from Endodontic treatment, and other treatment choices.

Risks: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling: sensitivity: bleeding: pain: infection: numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is translent but on infrequent occasions may be permanent: reaction to injections; changes in occlusion (biting) jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear neck or head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs) It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

OFFICE POLICY REGARDING INSURANCE: Our professional services are rendered and charged to you, not to the insurance company. However, if insurance information is given to the receptionist prior to treatment and verification of benefits can be made, we will accept assignment of the insurance benefits. It is the patients responsibility to pay the estimated portion of the fee not covered by the insurance upon completion of treatment. Accident cases or other benefit plans require prior approval.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor.

I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or silver filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

_____ _____

Patient/Parent Signature Date

Please fill out the Following Information:

(We understand you may have given us this information on the previous pages)

Patients Please Circle One For Each of the Following Questions:

Are You Allergic to ***LATEX***? YES NO

Are You Allergic to ***Novocain***? YES NO

Are You Allergic to ***ANY Medications***? YES NO
(If yes, please list):_____

Do You Need to ***Pre-Medicate*** Prior to Any Dental Appointments? YES NO

Are There Any ***Other*** Health Issues We Should Be Aware of? YES NO
(If yes, please explain):

_____

Who May We Thank For Sending You to Our Office?_____

Office Use *ONLY*

TODAYS PROCEDURES

EVALUATION TOOTH # _____

RCT # _____

OTHER _____

NEXT VISIT _____

TOTAL _____

Insurance, %_____