Welcome to Pocatello Periodontics

Where we strive to provide you with a warm, unique, and comfortable dental experience.

We provide all the latest advanced and up to date procedures and techniques in the industry.

Dr. Cady is a board certified periodontist, and has been serving the Pocatello area since 2013.

In order to make your first visit a smooth transition we ask you to do the following:

1: Please fill out all the enclosed paperwork. Having it filled out upon arrival keeps us on schedule and lets you and other patients be seen on time.

2: Please bring your dental insurance card with you to your appointment if you have Insurance. If you do not have a card, please be prepared to provide your dental ID# along with the group # and the carrier address and phone number.

We do ask all patients (cash pay or insured) to be prepared to pay for the consultation on the day of their first visit. If you are insured and the insurance pays for the consultation fee, this will be refunded to you or applied toward your treatment if you elect to have treatment with us.

3: If you wear any mouth appliance, bite guard, night guard, occlusal guard etc... please bring it to your consultation.

Thank You. We look forward to meeting you soon!!!

Michael Cady, DMD

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Confidential Patient Information

Patient Name ______________________ Nickname ______________ Date __________
Sex: Male ____ Female ____ Marital Status ____________ Date of Birth ______________ Present Age _______
Home Phone __________________ Work Phone __________________ Cell Phone __________________
Home Address ______________________________ City ______________ State _____ Zip________
Social Security ____________________Employer ______________________________
Employer's Address ______________________________ Email Address______________________
Referred to this office by ______________________________

If patient is a minor, please complete the following

Responsible Party ____________________________ Relation ________________ Date of Birth __________
Home Phone __________________ Work Phone __________________ Cell Phone __________________
Home Address ______________________________ City ________________ State _____ Zip________
Social Security __________________Employer ______________________________
Employer's Address ______________________________ Email Address______________________

Insurance Information

Subscriber's Name ____________________________ ID Number ______________________________
Social Security __________________ Date of Birth ____________ Relationship to Patient ______________
Employer ________________________ Employer's Address ______________________________
Insurance Company ______________________ Group Number ______________ Phone Number __________
Insurance Company Address____
Do you have Duel Coverage? Yes ____ No ____ If yes:
Subscriber's Name ____________________________ ID Number ______________________________
Social Security __________________ Date of Birth ____________ Relationship to Patient ______________
Employer ________________________ Employer's Address ______________________________
Insurance Company ______________________ Group Number ______________ Phone Number __________
Insurance Company Address____

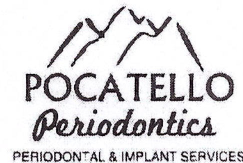
Are you currently considering or involved in bankruptcy? Yes _____ No _____
Emergency Information: Nearest relative not living with you. Name __________________Phone ___________

Consent:
I consent to the diagnostic procedures and treatment by Dr. Michael Cady as necessary for proper dental care. I consent to Dr. Michael Cady use and disclosure of my/or my child's records to carry out treatment, to obtain payment, and for anything related to treatment or payment. Additionally, I consent to the use and discloser of my/or my child's records to any dentist or other healthcare provider providing treatment to me. My consent to disclosure of records shall be effective until I revoke it in writing. I understand that where appropriate, credit bureau reports may be obtained.

I authorize payment directly to Dr. Michael Cady of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual charges for services, and that I am financially responsible for **payment in full of all accounts**. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT/Parent/Guardian Signature ______________________________ Date __________________



Michael Cady, DMD
1479 Bench Rd STE. B – Pocatello, Idaho 83201 – Phone 208-233-3660

- **BASIC POLICY:** Payment is **due at the time of service**. It is the patient's responsibility to know your insurance contract benefits, assure collection of insurance payments to us, and to negotiate with your insurance company over any disputed claims. We accept cash, checks, post-dated checks, Visa, MasterCard, and Care Credit. For cash patients (patients with no dental insurance), payment made in full on day of service by check or cash will receive a 10% discount. Implants and Sinus Augmentations are not eligible for discount.

- **IF YOU HAVE INSURANCE:** Your co-pay or deductible **is due at the time of service**. We will bill your insurance. If you are covered by Insurance, please present your identification card to the receptionist at the time of appointment. If you are **deemed ineligible** for your insurance benefits, you are responsible for all charges incurred.

- **INSURANCE CLAIMS:** If your insurance company rejects your claim, or they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full after your insurance payment, contact our Business Office to make payment arrangements. If you are **deemed ineligible** for your Insurance benefits, you are responsible for all charges incurred.

- **IF YOU DO NOT HAVE INSURANCE:** Payment is due at the time of service unless other arrangements have been made.

- **FORMS OF PAYMENT:** We accept payments in cash, check or money order, Visa, MasterCard and Care Credit. We will also accept post-dated checks.

- **WORKMAN'S COMPENSATION:** In the event it is determined by the Worker's Compensation board that the injury is not the result of a compensable Worker's Compensation case, we will bill any private insurance. The balance is your responsibility.

- **LIABILITY**: If pending settlement from insurance company or attorney, monthly payments are **required** until settlement is received.

- **MINOR PATIENTS**: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

- **INTEREST:** **Interest** of 1.5% per month (18%) per year) will be applied to any amount not paid after 60 days with a minimum charge of $1.00.

- **DELINQUENT ACCOUNTS:** Delinquent accounts over 90 days are turned over to our Collection Manager. If satisfactory arrangements for payment are not made, the account will be turned over to a collection agency or small claims court. By signing below you agree to pay **all** collections costs, attorney and/or court fees if collection procedures become necessary due to delinquent accounts.

- **NO SHOW FEE:** Regardless of your insurance carrier; we reserve the right to charge a $25.00 fee for missed appointments without the courtesy of 24 hours advance notice. Should you miss more than one appointment without 24 hours notice you may be advised to seek treatment elsewhere.

I have read and agreed to the Financial Policy for this office.

Patient ____ Date ____________________

Person Responsible for Account ____

Relationship to patient____

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Written Financial Policy

Thank you for choosing Michael Cady, DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several different methods of payment.

Payment Methods:

You can choose from:

- Cash, Check, Visa or MasterCard

We offer a 10% courtesy accounting adjustment to patients who have no dental insurance and that pay for their treatment with cash or check on the date of service. Implants and Sinus Augmentations are not eligible for this discount.

- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Allow you to pay over 6 months with NO INTEREST[1]
    - No annual fees or pre-payment penalties

Please note:

Michael Cady, DMD **requires payment in one of the above forms prior to the beginning of your treatment.** If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

We reserve the right to charge a fee of $25 for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice. If your appointment time was more than 1 hour you will be required to pay a 25% deposit before rescheduling your appointment.

Michael Cady, DMD charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.[2]Subject to credit approval[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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CREDIT-DEBIT-ACH POLICY

Patient Name:_________________________________

Date of Birth : _________________________________

I understand it is the policy of Michael Cady, DMD PC to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of the U.S. Law.

If, after a claim has been submitted to my insurance carrier:

1) The claim is denied by any reason OR
2) There is patient liability (i.e. Deductible, Co-Insurance, etc.) ; the office will send a statement notifying me of the balance due. If this amount is not paid within 30 days, the office manager will make a courtesy call to my home or mobile number requesting payment. If payment is not received within 7 days my credit or debit card will be charged the entire balance owed for treatment of services provided to me or my dependent.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event my credit or debit card has been charged for dental treatment or services, and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my account.

Please circle on the following

VISA – MC – Discover – American Express OR Checking Account – Savings Account

Credit or Debit Card # ____

Expiration Date: ____

Name of Card Holder (as it appears on card)____________________________

3 digit Verification number (back of card)______________________________

Zip Code associated with Credit or Debit Card:___________________________Checking or Savings account- please provide a voided check to verify routing and account number.

I hereby authorize______________________________ and its designated employees to charge my credit/debit card or Bank Account as designated above, the patient responsibility and/ or denied amount for dental treatment and services provided by the office. The charge will be based on the treatment rendered to me (or, my dependent) and the usual and customary charges made by the office for treatment and service. If payment is denied by my credit or debit card company or banking institution, I will pay the entire amount within 30 (thirty) days.

____ Date

Cardholder's/ Bank Account Signature

CONSENT TO DENTAL PHOTOGRAPHY

I, ________________________________ (Patient), authorize

Dr. Paul Michael Cady DMD, to take photographs, and/or videos of my face, jaws and

teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

· *Dental Records*

· *Dental Research*

· *Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books*

· *Marketing material, including websites and printed materials, patient education*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient) ________________________________ Date __________

POCATELLO
Periodontics
PERIODONTAL & IMPLANT SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________ have received (or understand I can obtain a copy by request) of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

____

____
Employee Name

____
Office Name

____
Employee Signature

____
Date