Sarasota Endodontic Solutions

Endodontics • Microsurgery

Mitchell R. Edlund, DDS, MS

Diplomate, American Board of Endodontics

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PATIENT INFORMATION

Name: Mr. / Mrs. / Ms. / Dr. _____
First Middle Initial Last

Birthdate:_____ Sex: Male Female

Marital Status: Single Married Widowed Domestic Partnership

Home Address: _____
Street City State Zip

Home Phone: (_____)_____ Cell/Work Phone: (_____)_____

Email: _____ SSN #: _____

Occupation: _____ Employer: _____

IF PATIENT IS A MINOR…

Parent/Guardian Name:_____ Parent/Guardian Birthdate:_____

EMERGENCY CONTACT

Name:_____ Phone: (_____)_____

*****PLEASE FILL OUT ALL PAGES OF THESE FORMS*****

DENTAL INSURANCE INFORMATION

(we are OUT-OF-NETWORK with all insurance carriers)

If you have dental insurance, we will be happy to send a claim to your dental insurance provider on your behalf. In order to do so, we will need all the below information filled out. We will also need a copy (front and back) of your dental insurance card. We are out-of-network with all insurance providers, but we will submit a dental claim if you provide us with all the information needed.

Note: We cannot send Dental Claims to your Medical Insurance or Medicare.

Dental Insurance? Yes □ No □

Patient's Name: _____DOB: _____ SSN: _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Dental Insurance Company: _____

Dental Claims Address: _____

Policy #/ID#/Member#:_____

Group #: _____

Patient Signature: _____

Reminder: All payment is due at the time of service, and we DO NOT accept insurance as a form of payment.

FIRST COAST SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

A CMS-Contracted Medicare Administrative Contractor

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE

Medicare Opt-Out Private Contract

Physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. This means that neither the physician, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician and the beneficiary that states that neither one can receive payment from Medicare for the services that were performed. "Part D Prescriber Enrollment Opt-Out." *CMS.gov Centers for Medicare & Medicaid Services*. N.p., 31 Oct. 2016. Web. 30 Mar. 2017. https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits

This contract between Mitchell R. Edlund, DDS, MS, PA and

(First Name)_____ (Last Name)_____
(Medicare beneficiary, referred to in this contract as "Patient) allows Dr. Edlund to provide treatment to Patient without being subject to Medicare limits. To do so, the law requires Dr. Edlund to "opt out" of Medicare and that no Medicare claim be filed for the treatment of Patient by Dr. Edlund.
Dr. Edlund represents that he is excluded from participation under the Medicare program under §1128, 1156, or 1892 of the Social Security Act; In addition, Patient and Dr. Edlund agree that Patient is not now facing an emergency or urgent health care situation.
By signing this contract, Patient does the following:

(i) agrees not to submit a Medicare claim (or request that Dr. Edlund submit a claim) for services or items supplied by Dr. Edlund, even if they are otherwise covered under Medicare;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dr. Edlund, and understands that no reimbursement will be provided under Medicare for those services or items. In particular, Patient will pay for such services at Dr. Edlund's usual rate, in accordance with Dr. Edlund's payment policies;

(iii) acknowledges that Medicare limits do not apply to amounts that Dr. Edlund may charge for such services or items

(iv) acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare; and

(v) acknowledges that Patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Medicare. Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other dentists who have not opted out.

Accepted and Agreed: Mitchell R. Edlund, DDS, MS, PA Date: _____

Accepted and Agreed: _____ Date: _____
(Patient or Patient's Legal Representative)

Original Contract Must Be Retained By Dr. Edlund. A Copy Will Be Provided To The Patient When Requested

*****PLEASE FILL OUT ALL PAGES OF THESE FORMS*****

MEDICAL HISTORY

1. **Are you having tooth pain or discomfort at this time?** Yes No

2. **Have you been under the care of a medical doctor during the past 2 years, other than regular physicals?**

   What condition(s) is/were treated? Yes No

   _____

3. **Are you now taking any MEDICATIONS? Please list:** Yes No

_____

_____

4. **Please list any ALLERGIES including LATEX**:

_____

5. **Are you taking or have you taken Fosamax or other bone medications?** Yes No

6. **Does your physician advise you to pre-medicate with antibiotics every time you have dental procedures, like for a joint replacement or heart issue?**

   Reason: _____ Yes No

Please circle any of the following you have had or presently have:

High Blood Pressure	Venereal Disease	Drug or Alcohol Addiction	Cancer
Heart Murmur	Oral Herpes	Glaucoma	TMJ Disorder
Mitral Valve Prolapse	Asthma	Sinus Trouble	Chronic Cough
Artificial Joint (hip, knee)	Allergic to Latex	Thyroid Problems	Allergies/Hives
Rheumatic Fever	Low Blood Pressure	Diabetes	Blood Transfusion
Congenital Heart Disease	Angina Pectoris	Stomach ulcers/Colitis	Bruise Easily
Heart Disease, Stroke, or Heart Attack	Heart Pacemaker	Hepatitis, Jaundice, or Liver Disease	Hemophilia
Artificial Heart Valve	Heart Surgery	Kidney Trouble	Developmentally Disabled
Anemia	Tuberculosis	Psychiatric Treatment	AIDS
Sickle Cell Anemia	Emphysema	Fainting/Dizzy Spells	HIV Positive
	Chemotherapy	Epilepsy or Seizures	Contagious Diseases
	Radiation Therapy		

Other: _____

For Women Only: Are you pregnant? Yes No How Many Months? _____
Nursing? Yes No
Taking Birth Control Pills? Yes No

Patient Signature: _____ Date: _____

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CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

Occasionally, medication will be prescribed by Dr. Edlund. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call Dr. Edlund immediately. It is the patient's responsibility to report any changes in his/her medical history to Dr. Edlund.

I understand that root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

Prior to treatment, I will ensure that all of my questions have been answered by Dr. Mitchell R. Edlund and that I fully understand the above statements in this consent form.

Note: All medical records will be kept strictly confidential.

Patient (Signature): _____ Date: _____

(If patient is under the age of 18, the signature of a parent or guardian is required.)

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FINANCIAL AGREEMENT

- If we **ONLY** provide Endodontic Evaluation (Consultation with/without Cone Beam CT-Scan):

  This consists of an examination and testing, discussing the likelihood of maintaining the tooth and treatment options available to you. Full payment is due at the time of service.

- If we provide **TREATMENT**:

  Those without dental insurance: Full payment is due upon completion of treatment, due at the time of service. Payment may be made with cash, check, or Visa, Mastercard, American Express, Discover, and CareCredit

  Those with dental insurance: Because we are not in-network with any insurance companies, we will usually take payment for the full fee charged upon completion of treatment and file a claim for your insurance to reimburse you for what they cover. If you prefer to pay only the portion due that your insurance will not cover, we can submit a pre-determination estimate to your insurance company prior to treatment. Since this varies for each individual and insurance company, it may sometimes take up to a month before we have received this estimate. We will submit your insurance claims for you.

- If your insurance pays **more** than the estimated amount, a refund check from this office will be mailed within 1 month of the date payment is received in our office. We usually batch them at the end of the month.

- If your insurance pays **less** than the estimated amount, you will receive a statement from this office. We usually do not send monthly statements, so prompt attention is greatly appreciated!

Please note Dr. Edlund is NOT in-network with any insurance plans and it is your responsibility as the patient to understand the terms of your own insurance plan.

NOTE: If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them. Also please note that payment is to be made in full within thirty days after we send the first statement. If payment is not made, we will turn your account over to our collection agency. There is a $39.00 NSF fee for any returned checks.

I understand that as a recipient of dental care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. I agree that the determination of the professional services to be rendered by Dr. Edlund and the fees to compensate the doctor for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for services provided, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.). The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE.

Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices (located on the following page):

Signature *Date*

*****PLEASE FILL OUT ALL PAGES OF THESE FORMS*****