Ashland Family Dentistry
A Division of Central Virginia Dental Care, PLC.
Louis J. Korpics Jr., DDS
and Associates

Welcome to Ashland Family Dentistry, the offices of Dr. Louis J. Korpics Jr., and associates. It is our goal to make this visit a satisfying one for you. This letter is to inform you of the office policies. Please take a moment to read them and if you have any questions regarding these policies, feel free to ask the receptionist.

PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Take x-rays, study models, photos and other diagnostic aids for material as needed to make a thorough diagnosis. Obtain payment from third-party payers.
- Submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file". I am responsible for payment regardless of coverage provided.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You may obtain a copy of the Notice of Privacy Practices at any time by contacting our office.

Please list authorized persons with whom we may discuss your Protected Health Information:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

INSURANCE POLICIES

Our office deals with many different insurance companies. But because the number of policies is so numerous, please realize that payment for dental services is directly your responsibility. Your insurance carrier has contracted with you to pay a portion of your dental costs. In most cases, no insurance company will pay 100% of all dental costs.

At the time of your appointment please update any changes in your insurance coverage to ensure we have accurate information to submit for payment through either electronic submission and/or paper.

At the completion of your treatment for the day, you will be asked to pay your estimated percentage of the dental treatment not covered by your insurance. Any overpayment made by you will be refunded promptly upon payment by the insurance company. We offer a variety of payment options to accommodate your financial needs, including: Cash/Checks, Visa/Mastercard/Discover, and Care Credit. If an account goes to collections, you will be responsible for any and all attorney fees and/or court costs incurred to collect on the account.

Our office uses resin (tooth-colored) and amalgam (metal) fillings. Some insurance companies will downgrade your benefit to the price of an amalgam filling and charge the patient the difference in cost. We will bill you for the difference of the resin filling in which your insurance did not cover after the payment has been received. If you have any questions regarding this policy, please ask a staff member to explain in more detail.

MISSED APPOINTMENTS/ RETURNED CHECK FEES

I acknowledge that cancellation of an appointment requires at least **48 hours** notice. Failure to do so will result in a charge of $50 per hour of appointment. I have been informed there will be a $50 fee for any checks returned to your office.

PATIENT INITIALS: _____

PRESCRIPTION REFILLS

It is preferred by this office and by the pharmacy that a refill request is done by calling the pharmacy and not this office. Any refill that is questionable will be handled by the pharmacist contacting this office.

At Ashland Family Dentistry, our #1 priority is the patient. Our attention is given first and foremost to the patient who has a scheduled appointment. Remember that the doctors and assistants are with these patients during business hours and cannot readily come to the phone. Please respect this policy.

Patient/Guardian Signature: _____ Printed Name: _____

Relationship to Patient: _____ Date: _____

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and Associates

130 Thompson Street, Ste I
Ashland, VA 23005
(804) 798-2776

17488 Center Drive, Ste 3A
Ruther Glen, VA 22546
(804) 448-1102

PATIENT INFORMATION:

Date: _____

Name: _____ Preferred #: (_____) _____

Address: _____ Business #: (_____)_____

City, State, Zip: _____ Cell #: (_____)_____

Date of Birth: _____ Social Security Number: _____

Email Address: _____

Employer: _____ Occupation: _____

Circle One: Male / Female Circle One: Single / Married / Separated / Widow / Child

Name of Spouse: _____ Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY: If same as above, check here: ⬭

Responsible Party Name: _____ Daytime Phone: _____

Address (City, State, Zip): _____ Mobile Phone: _____

_____ Date of Birth: _____

Social Security Number: _____ Relationship to Patient: _____

DENTAL BENEFITS:

Insurance Company Name: _____ Phone Number: _____

Insurance Company Claims Address: _____

_____

Policy ID/ Subscriber Number: _____ Policy Group Number: _____

Policy Holder/ Subscriber Name: _____

Policy Holder/ Subscriber Home Address: _____

_____

Date of Birth: _____ Social Security Number: _____ Preferred #: (_____)_____

Employer Name: _____ Employer Phone: _____

Are you covered by another or secondary insurance? Yes: _____ No: _____
If YES, please let us know so a copy of card is made.

If you have purchased a Discount Plan, please fill out below information.

Company Name: _____ Effective Date: _____ Expiration Date: _____