ARPIN
FAMILY DENTISTRY
GENTLE METHODS•TRUSTED EXPERIENCE•SATISFIED PATIENTS
1367 North Mt. Auburn Rd. • Cape Girardeau, MO 63701 • (573) 334-3131

MISSION STATEMENT

"With an experienced and friendly staff, we believe in creating high quality dental care, exceptional education, and encouragement of personal dental hygiene for our family of patients. We will provide this dental care to our patients in an ethical, compassionate, and cost efficient manner. We will continually strive to provide you and your family's dental care in a comforting and enthusiastic atmostphere. We pledge to create unsurpassed patient satisfaction, practice growth, and personal enrichment through our professional dedication." Dr. Arpin and staff

The following provides you and our office the necessary and often required information needed to properly provide you with your dental needs. Please carefully read and complete all sides and pages. Feel free to ask the receptionist any questions you may have.

Welcome!

Thank you for choosing our practice for all of your dental care needs. You will find that Dr. J.P. Arpin and his staff have a way of providing dental care which goes beyond your expectations. Our warm smiles, friendly personalities, sincerity and genuine concern for our patients is apparent from the moment you walk into our office.

Our office provides a full range of preventative, restorative, cosmetic and aesthetic services which include porcelain veneers, bleaching, bonded fillings and crowns, full and partial removable dentures, extractions, root canal treatment, periodontal therapy, implant reconstruction, and emergency services. We strive to stay current with the latest state-of-the-art techniques for providing dental care so we can best inform our patients on how we can serve them and help them meet their dental needs. The wonderful thing about dentistry today is that it is affordable and attainable. Everyone can have a beautiful smile!

All of our treatment recommendations and financial decisions are made with the highest level of integrity and ethics. We will provide only the necessary dental restorations and care for our patients that we would desire in our own mouths and those of our own families.

One convenient location... One great dental team... Lots of smiling faces!

Once again, welcome, and thank you for choosing us to provide your dental care.

OFFICE POLICIES AND PROCEDURES

We have three simple policies that we feel are important to share with our patients. We strongly believe in our work and professional efforts, and we therefore ask you to review these points.

Commitment to Treatment… We believe all treatment begun should be completed. Incomplete treatment leads to problems, complications, misunderstandings, and usually disease.

Commitment to Appointments…An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for our service. Our resolve is firm in this. Frequent cancellations or constant short-notice changes will result in scheduling fees not covered by insurance and in some cases, dismissal from our practice. Your cooperation will acknowledge that we have a mutual respect for each others time.

Commitment to Financial Arrangements… We believe we have the responsibility to provide you the best personal, professional care, skill, and judgment in planning and delivering your dental treatment. Your payment will reimburse us for our services.

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment ☐ the patient's spouse

Employer Name: _____ Occupation: _____

Address: _____
STREET CITY STATE ZIP CODE

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ SS# or Subscriber ID _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Phone: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ SS# _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Phone: _____

CONSENTS

As a condition of your treatment by this office, financial arrangements must be made in advance. I understand that the fee estimate listed for proposed dental care can only be extended for a period of three months from the date of the initial treatment recommendations.

IF YOU WILL BE PAYING FOR TREATMENT PERSONALLY: Fees are due on the day of service and may be paid by check, cash, Master Card, Visa or Care Credit financing. If payment in full is not possible, alternate arrangements must be made and agreed upon by both patient and dentist and a financial agreement presented and signed.

FINANCING: Short and long term financing may be arranged through our office with an independent financial credit services. Instant approvals are available upon application in our office or through Care Credit's web site at www.CareCredit.com. In some cases, payments may be interest free.

IF YOU PLAN ON UTILIZING DENTAL INSURANCE: Dental insurance coverage is a contract between you and your carrier or employer and is utilized to generally cover only a PORTION of your total dental fees. The amount paid by the insurance company depends on what you or your employer specified when the plan was initiated. We will file the required insurance forms as a courtesy to our patients. Your personal pay requirement will be expected at the time of service for the ESTIMATED portion your insurance will not cover (your co-payment). However, full payment for professional service is YOUR responsibility, regardless of the amount paid by your insurance company. Generally, processing claims take between 30-60 days. We will do everything we can to assist in making collections from insurance companies on the charges for your dental treatment completed and will credit any such collections to the proper patient account. However, if after 60 days, the claim has not been processed by your insurance payor, the remaining unpaid balance becomes the patients responsibility and payable in full. You will be promptly issued a refund if an insurance check is received after the 60 days have elapsed. Patients who utilize dental insurance acknowledge that this office will not render services on the assumption that our charges will be paid by an insurance company. I agree to be responsible for all charges for the dental services and materials provided to me, but not paid for by my dental benefit plan, unless the treating dentist has a contractual agreement with plans prohibiting all or a portion of such charges (PPO plans), to the extent permitted under applicable law.

ASSIGNMENT OF INSURANCE: I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the named dental entity: The office of J.P. Arpin, DDS.

RELEASE OF INFORMATION: I hereby authorize J.P. Arpin, DDS to release information necessary to file a claim with my insurance company. In addition, I authorize the release of my dental/medical information by or between any of my treating health professional and my insurer, health benefits payor or other entity, including but not limited to, third party administrators, management companies and provider networks involved in the administration of my health benefits.

ASSIGNMENT OF CONTRACT: I grant my permission to you or your assignee to telephone me at home, wireless phone or at my work to discuss matter related to my account, treatment, or appointment scheduling. I also grant permission for your office or assignee to contact me via electronic communications, including Emails and text messaging, unless I specifically opt out of such electronic communication.

_____ _____

Signature of patient, parent, or guardian Date

COMMITMENT AND INTENTION OF ACCOUNT: NOTICE: Do not sign this agreement before you read and agree to the conditions. You are entitled to a copy of the agreement at the time of signature. Keep it to protect your legal rights.

A service charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days past due, unless a previously written financial arrangement is in force.

I authorize treatment of the person named below and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself and members of my family, shown by statements, promptly upon presentation thereof unless credit arrangements are in force. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of the billing date. In the event of collection and or legal action to collect an unpaid balance due for dental services rendered to me or my family, I/we agree to pay the 40% collection fee and reasonable attorney's fees or other such costs as the Court determines proper.

In consideration for the professional services rendered to me, I agree to pay for the charges for my dental service as the services are rendered or within 5 days of billing if credit shall be extended. I understand I am financially responsible for payment of this account regardless of insurance or other third party involvement.

I have read the above conditions of treatment and payment and agree to it's content.

_____ _____

Signature of patient, parent, or guardian Date

I hereby acknowledge receipt of a copy of this form:_____ _____

Signature Date