Andrew D. Mylander, D.M.D.
2315 Grace Avenue · New Bern, NC 28562 • (252) 633-2261

Please read thoroughly, ask questions if needed and sign prior to treatment.

_____ **HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT & CONSENT TO PROCEED:** I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Mylander of any changes at any subsequent appointment.

_____ I authorize Andrew D. Mylander, DMD and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

_____ I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

_____ I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results which mayor may not be achieved for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ The undersigned hereby authorizes Dr. Andrew D. Mylander to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's needs. I also authorize Dr. Mylander to administer any and all forms of medication, and therapy that may be indicated.

_____ **Patient Responsibilities:** We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

_____ **Payment:** Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Cash, Check or Credit Card (MasterCard, Visa, Discover, American Express and Care Credit). A copy of your consumer credit report will be obtained by Andrew D. Mylander, DMD, PLLC.

_____ **Returned Checks:** In the event that your check be returned for insufficient funds, your account will be electronically debited or bank drafted for the amount of the check plus any applicable fees by ChecXchange. The use of a check is your acknowledgement and acceptance of this policy and its terms and conditions.

_____ **Balances older than 30 days:** May be subject to additional collection fees and interest charges of 1.5% per month or 18% annually. These additional fees will be applied to the unpaid balance of your account.

_____ **Past due accounts:** In the event that the account is not paid in full after 90 days, we may refer the account to an outside collection agency.

_____ **Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Dr. Andrew D. Mylander is a contracted provider with Delta Dental Premier, and Guardian only.

_____ **If we are a contracted provider with your plan,** you are responsible only for your portion of the approved fees as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

_____ **If we are not a contracted provider with your dental benefit plan,** it is the patient's responsibility to verify with the insurance company / benefit plan whether the plan allows patients to receive reimbursement for service from out-of-network providers.

If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your insurance company / benefit plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. *You are always responsible for any charges that insurance does not pay.*

_____ **As a courtesy to you,** we file your insurance claim electronically. We require that you pay your estimated co-payment and deductible at the time of service.

_____ **Scheduling of Appointments:** Your appointment time has been reserved exclusively for you. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. We do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of 20% (minimum $25.00) will be charged.

_____ **Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contain in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

____ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____

____ I consent only to receiving appointment reminders via email or test. I understand I can with draw my consent at any time. My email address is _____ My cell phone number is _____

_____ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

AUTHORIZATIONS: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consent to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize Andrew D. Mylander, DMD, PLLC to obtain a copy of my consumer credit report. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to Dr. Andrew D. Mylander otherwise payable to me. YES / NO (Circle One) _____ (initial)

I understand I am responsible (regardless of my dental benefit plan and/or insurance) for any charges incurred for services rendered. _____ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

PATIENT'S NAME: **<<first_name>> <<last_name>>**

Signature _____ ___ Date _____

(Patient, legal guardian or authorized agent of patient)