Financial Policy

Kevin N. Schierlinger, D.D.S., P.C.
5895 John R
Troy, MI 48085
(248) 828-8128

This is an agreement between Kevin N. Schierlinger, D.D.S., P.C. as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Kevin N. Schierlinger, D.D.S., P.C.

By executing this agreement, you are agreeing to pay for all services that are received.

Treatment Recommendations: Treatment recommendations are based on your individual needs. Fees are not typically explained prior to rendering treatment. When you accept treatment in our office, you are accepting responsibility for the cost of all services rendered on your behalf or that of your dependents. If you would like to review the fees prior to accepting treatment, please ask to speak to our Financial Coordinator. She will be happy to give you a breakdown of the fees involved.

Payment Policy: Payment for services is due at the time the service is rendered. On treatment requiring multiple appointments, you may choose to pay a minimum of 50% at the initial appointment. The balance may be divided over the remaining appointments and is due in full upon completion. If treatment is suspended or terminated, the remaining balance will become due immediately. We accept cash, checks, and major credit cards.

Credit Policy: In order to extend credit in our office, you give us permission to run a credit report and make other credit inquiries that we determine necessary. With approved credit, we offer a wide variety of both in-office payment arrangements, and third-party interest-free financing. Please ask to speak to our Financial Coordinator with any question regarding your dental investment or to apply for credit.

Insurance: Dental Insurance is a contract between you and your insurance company. We are not party to this contract in most cases. We are happy to file the forms necessary to assure you receive the full benefit of your dental insurance, and we gladly accept direct payment from most insurance companies. However, you are ultimately responsible for all charges that your insurance company does not cover. We will estimate what your insurance company may pay, but we cannot guarantee this coverage. It is the insurance company that makes the final determination of your eligibility and coverage. Therefore, the amount due our office is subject to change once the insurance payment is received. It is important that you understand the full extent of your insurance coverage. If your insurance company does not respond within 60 days, the remaining balance will become your responsibility.

Pre-payment courtesy: For charges exceeding $200.00, a 5% courtesy will be extended for full cash or check payment made prior to the start of treatment.

Senior Citizen Discount: Patients 65 or older are eligible for a 10% discount if payment is received in full on the date of service.

General Discounts: Discounts cannot be combined with any promotional or other courtesy discounts. Discounts will apply only when payment in full is received on the date of service. Discounts may no longer be offered on accounts with a history of poor credit or missed appointments.

The Financial Policy continues on the back side of this page.

Patients Name: _____

Signature of Responsible Party: _____ **Date:** _____

Monthly Statements: Monthly statements will be sent for any patient balance remaining on your account. The balance on your statement is due by the date shown on the statement. Finance charges will apply if payment is not received by the due date.

Finance Charge: Unless other arrangements have been established in writing, a finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a quarter percent (1.25%) per month or an **ANNUAL PERCENTAGE RATE** of fifteen percent (15%). The finance charge on your account is computed by applying the periodic rate (1.25%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Returned Checks: There is a fee (currently $35.00) for any check returned by the bank. Upon receiving the returned check, our office will attempt to contact the financial institution to verify funds. If funds have become available, we will redeposit the check and bill you for the returned check fee. If funds are still not available, our office will notify you by phone or in writing via certified mail. If the amount due is not paid with cash within seven business days of receipt of notice, it will be considered as intent to defraud and may be reported to the Troy Police Department.

Missed Appointment Fee: The second time a patient does not show up for an appointment, or cancels with less than 24 hour notice, a fee (currently $30.00) may be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past Due Accounts: We will make several attempts to contact you if your account becomes past due. If we are unable to reach you, if you have expressed an unwillingness to pay, or if your balance becomes 120 days overdue, your account will become delinquent. If your account becomes delinquent, we will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau. If collection efforts are required, you shall be liable for all cost of collection, including reasonable attorney's fees. If your account is referred to an outside collection agency, a collection fee will be added to your account. In case of suit, you agree the venue shall be in Oakland County, Michigan.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney, collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, which may include your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, which may include your payment history.

Worker's Compensation, Auto Insurance and Personal Injury Claims: We will gladly process your insurance or lawsuit claim and forward any necessary records as you request, however, payment of the bill remains the patient's responsibility. Payment is expected at the time of service, we will request the insurance carrier send their payment directly to you.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

KEVIN N. SCHIERLINGER, D.D.S., P.C.

MEDICAL HISTORY

Patient Name:_____ Birthdate:_____

Are you under a physician's care now? ☐ Yes ☐ No

If yes please explain:_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes for what and when?_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes please explain: _____

Are you taking any medications, pill, or drugs? ☐ Yes ☐ No

If yes please list or attach a copy: _____

Have you ever taken Fosamaz, Boniva, Actonel or any other medications containing biophosphonates? ☐ Yes ☐ No

If yes: _____

Are you on a special diet? ☐ Yes ☐ No

If yes: _____

Do you use tobacco? ☐ Yes ☐ No

If yes: _____

Do you use controlled substances? ☐ Yes ☐ No

If yes: _____

Do you require pre-medications before dental visits? ☐ Yes ☐ No

If yes: _____

Women: Are you . . .

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? _____

Do you have, or have you had any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Chest pains	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Easily Wounded	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

TIME 03:09 PM DATE 5/17/2022

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact:

Contact Phone:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Symptoms of Temporomandibular Dysfunction

The jaw joints, called the temporomandibular joints or "TMJ", are among the most complex joints in the body. They are the only joints which must be in complete harmony with each other in order to work properly. When this complex system of muscles, ligaments, discs and bones do not work properly together, it could result in a condition known as TMD, for Temporomandibular Dysfunction. Following is a list of symptoms which could be related to the jaw muscles and joints. Experiencing any of these symptoms could be a sign of TMD. Many patients experience symptoms, yet have no apparent loss of function. However, sometimes the symptoms slowly get worse and require treatment. Awareness of these symptoms in early stages is also important in diagnosing the cause of other dental conditions such as fractured teeth or bone loss. Monitoring symptoms is the only way to properly diagnose TMD. Please indicate if you have experienced any of the following symptoms. We will continue to monitor at future appointments.

Patient Symptoms:

	Date:
❑ Pain in the jaw muscles	
❑ Facial muscles feel tight constantly (face feels tired)	
❑ Frequent headaches	
❑ Pain in one or both jaw joints	
❑ Clicking, grating or cracking sound in one or both jaw joints	
❑ Limited opening with or without pain	
❑ Inability to find a consistent bite	
❑ Lower jaw locks closed or open	
❑ Difficulty chewing	
❑ Inability to open or close smoothly	
❑ Teeth tender to pressure/chewing	
❑ Sensitivity to temperature	
❑ Teeth grinding	
❑ Numbness in any area of the face/neck	
❑ Unexplained tooth pain	
❑ Clenching	

	Date:
❑ Sensitivity to sound	
❑ Recent loss of hearing	
❑ Pain behind the eye	
❑ Light sensitivity	
❑ Excessive tearing	
❑ Blurred vision	
❑ Difficulty swallowing	
❑ Pain in tongue, cheek, or lip	
❑ Chronic mouth breathing	
❑ Snoring	
❑ Sleep apnea	
❑ Crowded upper and/or lower teeth	
❑ Scalloped tongue	
❑ Tongue chewing	
❑ Fullness in one or both ears	
❑ Ear pain	
❑ Dizziness	
❑ Ringing in ear	
❑ Buzzing of ears	

Doctor Findings:

❑ Abfractions, bone loss, gum recession	
❑ Open contacts with no periodontal rational	
❑ Anterior and/or posterior wear facets	
❑ Tilted teeth (mostly lingual inclination)	
❑ Premature occlusal or incisal tooth contact	

❑ Cervical erosion	
❑ Opening/closing lateral deviation of lower jaw	
❑ Depressed curve of Spee	
❑ Bicuspid drop off	
❑ Fractured teeth or restorations	
❑ Lack of posterior support	
❑ Torus mandibularis	
❑ Decrease in opening measurement	
OPENING MEASUREMENT	

Notes:

_____

_____

_____
Patient Name (printed)

_____ _____
Patient Signature Date

Covid Screening

Patient Name:_____ Date: _____

Are you experiencing any of the following symptoms?

- ☐ Fever, chills, sweating
- ☐ New or worsening cough
- ☐ Fatigue
- ☐ Body aches
- ☐ Diarrhea
- ☐ Reduced sense of smell and/or taste
- ☐ Mild to moderate difficulty breathing
- ☐ Sore throat
- ☐ Runny nose
- ☐ None of the above

If yes to any, what do you contribute these symptoms to?

_____

Are you taking any fever reducing medications?

☐ YES What, when and why? _____
☐ NO

In the last 14 days, have you been around someone who is known to have COVID-19, or anyone who is having symptoms?

☐YES explain: _____
☐NO

For both vaccinated and non-vaccinated persons, if you have been exposed to Covid you must wear a mask in public for 10 days. Since you must remove your mask during treatment in our office, your appointment would have to be postponed until the 10 days have passed.

Thank you for your understanding and cooperation.

Patient Signature:_____Date: _____

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor-to make a thorough diagnosis of

   (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (15% APR) may be added to my account.

Please be advised that even though there may be Dental Insurance coverage, the ultimate financial responsibility is that of the patient or parent in situation regarding dependents. Dental Insurance is a benefit to you from your employer. There are contractual limitations between your employer and most Dental Insurance carriers, of which we are not liable. Please inform yourself of the full extent of your insurance coverage. We will be happy to explain but will not guarantee this coverage.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature _____ Patient Name (please print) _____

Date: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

Office Personnel (signature) _____ Office Personnel (print name) _____

Date: _____

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature _____ Patient Name (please print) _____

Date: _____