Welcome to Limestone Dentistry LLC,

Dr. Eric Thornton, D.M.D and staff would like to thank you for selecting our office for your dental needs. Our goal is to provide you with the highest quality dental care in the most gentle, efficient and enjoyable manner.

At any time if you have questions concerning your restorative, preventative or cosmetic care please do not hesitate to ask any staff member or Dr. Thornton.

Dental Insurance

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. Returned checks will be subjected to additional fees.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not; however, enter into a dispute with your insurance company over any claim.

Financial Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Limestone Dentistry LLC. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

General Consent to Treatment:

I hereby authorize and direct Dr. Thornton and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

In general terms, the dental procedure(s) can include but not be limited to:

a. Comprehensive oral examination, x-rays, cleaning of the teeth, and application of topical fluoride.

b. Treatment of diseased or injured teeth with dental restorations (fillings and/or crowns).

c. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infections.

I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustments and/or replacement.

I authorize Dr. Thornton to forward a review of finds and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information

Responsible Party: As the responsible party, in the case where my spouse and/or children are also patients at Limestone Dentistry LLC, signing this Office Policies form will apply to them and their accounts as well.

_____ _____

Signature of Responsible Party Date

_____

Print Name of Responsible Party

Acknowledgement of Receipt of Notice of Privacy Practices
**You may refuse to sign this Acknowledgement*

I acknowledge that I have received a copy of Limestone Dentistry LLC, HIPAA Notice of Privacy Practices.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Name of Personal Representative Authority of Personal Representative to Sign for Patient (check one): □ Parent □ Guardian □ Power of Attorney □ Other: _____

Signature of Personal Representative _____

Whom May we Release your Personal Health/Dental Information to?

___Spouse _____Phone number_____

___Relative _____Phone number_____

___Other _____Phone number_____

Dental Office Use Only: I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Name of Personal Representative Authority of Personal Representative to Sign for Patient (check one): □ Parent □ Guardian □ Power of Attorney □ Other: _____

_____ _____
Staff Member Signature Date