Mandy Holley, DDS, PA
3613 Williams Dr., Bldg. 10, Ste. 1001
Georgetown, TX 78628
Ph (512) 819-9100 Fax (512) 819-9128

GUEST REGISTRATION

GUEST INFORMATION

Name____
Address____
City/State/Zip____
Home Phone____
Employer____
Work Phone____Ext.________________
Cell/Other #____
Social Security #___________________________DOB______________________________
Marital Status (Circle One) S M Sex (Circle One) M F
Email Address____

POLICY HOLDER INFORMATION

Name____
Address____
City/State/Zip____
Home Phone____
Employer____
Work Phone____Ext.________________
Social Security #___________________________DOB______________________________
Dental Insurance________________________Group Number____________________________

WHOM MAY WE THANK FOR REFERRING YOU?

Family Member_______________Friend_______________Yellow Pages_________________
Sign_______________Mail_______________Other-Specify____________________________

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF AN EMERGENCY

Name____
Home Phone____
Work Phone____Ext.________________
Physician's name & phone ____
Preferred pharmacy & phone ____

LEVEL OF CARE

The greatest service we provide to our patients is to give them a well designed plan for accomplishing their dental goals. By answering the following questions, we can better understand your dental goals, which will enable us to give you our very best.

Please rate each statement below from 1 to 10 (10 being most important, 1 being least important). Please circle any topic you wish to discuss further.

______ To keep my teeth a lifetime (LONGEVITY)

______ To improve the appearance of my smile

______ To chew better

______ To be free from pain and sensitivity

Please check whatever expresses how you feel about the following:

HOW HEALTHY DO YOU WANT YOUR MOUTH TO BE?

______ The best it can possibly be

______ Average

______ I do not really care

AT WHAT POINT IN TIME DO YOU WANT US TO RECOMMEND TREATMENT?

______ When something is not ideal

______ When something is beginning to worsen

______ Just before it hurts or breaks

______ Just before I lose my tooth/teeth

WHAT QUALITY OF SERVICE/DENTISTRY SHOULD WE RECOMMEND TO YOU?

______ Ideal/the best

______ Average

______ Only patchwork, I do not want anything more

Mandy Holley, DDS, PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

PRIVACY PRACTICES:

In compliance with the Health Insurance Privacy and Accountability Act (HIPAA), all information pertaining to you or your care will be kept strictly confidential. You have the right to review your records. At times, it may be necessary to convey your private information to other parties, including other doctors, for the benefit of your health; insurance companies in order to resolve treatment or reimbursement issues; attorneys for the resolution of medical/legal issues; or to law enforcement or government agencies if a court order or warrant is presented. Your private information will only be released upon your permission by phone, mail, or fax except in the case of a legal warrant or court order. A record of all conveyance involving your private information will be kept in your file. You have the right to specify means and receiving entities for the conveyance of your private information. You have the right to request that your information be changed if you feel that it is incorrect. By my signature below, I understand and agree with the privacy practices of Mandy Holley, DDS, PA.

I, ___________________________________ have received a copy of Dr. Mandy Holley's Notice of Privacy Practices.

____

(Signature)

____

(Date)

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgment, however:
□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement

Mandy Holley, DDS, PA

Financial Policy

We are pleased that you have chosen Dr. Holley for your dental needs. In order to better inform you, please read the following summary of our financial policy.

Insurance

You, as the patient, are responsible for all charges regardless of insurance coverage. As a courtesy, we are happy to file claims with your primary insurance company for services rendered. Your deductible, co-payment, and/or co-insurance are due at the time of service. However, if we have not received payment from your insurance company within 60 days from the date of the service, you will be expected to pay the balance in full.

Payment

We realize that patients have financial needs, and we will do our best to find a solution that will work best for you. We accept Visa, MasterCard, Discover, American Express, and personal checks with proper identification. Returned checks may be recovered electronically along with the state allowed recovery fee. Payment of co-insurance, deductible, and/or co-payment is required at the time the services are rendered unless other arrangements have been made in advance. There will be a $25 fee assessed for returned checks and accounts sent to collections.

Patients with outstanding balances 60 days or more overdue must make arrangements for payment prior to scheduling future appointments.

Missed Appointments/Late Cancellations

Your appointment is time set aside especially for you. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. Please call our office and speak to an appropriate coordinator 24 hours prior to your appointment if you must cancel or reschedule. Unfortunately, if the required notice is not given, a ***minimum*** fee of $25 will be charged and immediately payable. Excessive abuse of this policy may result in discharge from the practice.

I have read and understand Dr. Holley's financial policy. I agree to assign insurance benefits to Dr. Holley when necessary. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

______________________________	______________________________
Signature	Witness
______________________________	______________________________
Date	Time
______________________________	______________________________
Relationship if signed by Patient's Representative	Printed Name of Witness