Marks Family Dentistry

Norman J. Marks, D.D.S., FAGD • S. Aaron Marks, D.D.S. • Brandon S. Marks, D.D.S.

We are delighted that you have selected our family for your dental health care. We and our staff truly love our profession and enjoy making state of the art dental care available for all our patients.

We believe it is vitally important for us to have full knowledge of your total health in order to provide you with the best comprehensive dental care. Each year more research becomes available to reveal the many ways your dental health impacts and reflects your physical health. Research also reveals your medications may limit or alter your dental care.

This research is the reason we have expanded our patient registration forms to include comprehensive dental and medical histories. By providing detailed information about your physical health, as well as your medications (both non-prescription and prescription) and supplements, you enable us to make a better diagnosis and ensure your participation and understanding of recommendations regarding your dental care.

We realize these forms are extensive, but we believe your taking the time to complete them as fully and accurately as possible will be to your benefit. **Please complete the following prior to your first appointment and bring them with you so the dentist or hygienist can review the information with you:**

"Patient Registration"
"Dental History"
"Medical History"

Please remember at each visit to notify us of any changes in your medications, your health, or your insurance so we can document those changes in your records.

You do not need to return the following documents because your signature on your "Patient Registration" confirms that you have received this information:

"Dental Insurance"
"Payment Options"
"Privacy Practices for Protected Health" known as "HIPAA"

If you have questions regarding any of these documents, please do not hesitate to contact us or ask questions at your appointment. For a broad range of information about dentistry and our office, please check our website **www.MarksFamilyDentistry.com**

Thank you for selecting Marks Family Dentistry. We look forward to seeing you.

Sincerely,

Norman J. Marks, D.D.S. S. Aaron Marks, D.D.S. Brandon S. Marks, D.D.S.

Marks Family Dentistry

PATIENT REGISTRATION

_____ _____ _____/_____/_____
Patient's Name (Please Print) Preferred Name Date of Birth

_____ _____-_____-_____
Street City State Zip Social Security Number

_(_____)_____ _(_____)_____ _____
Home Phone Cell Phone Email Address

_____ _____ _____ _____
Patient Employed By Work Phone Spouse or Parent

_____ _____-_____-_____
If spouse or parent is policy holder: Employed By Social Security Number

_____ _____ _____
Primary Insurance Company Policy Holder Group Number

_____ _(_____)_____
ID Number (if not SSN) Phone Number

_____ _____ _____
Secondary Insurance Company Policy Holder Group Number

_____ _(_____)_____
ID Number (if not SSN) Phone Number

_____ _____ _____-_____-_____
Person Responsible for Account Relationship Social Security Number

_____ _(_____)_____ _(_____)_____
Spouse or Emergency Contact Phone 1 Phone 2

_____
How did you learn about our office?

INSURANCE

1. I am aware of Marks Family Dentistry's policies regarding dental insurance, as well as the benefits and limits of my own dental insurance policy. I have had the opportunity to review Marks Family Dentistry's statement regarding dental insurance and am aware of the following:

- Recommendations regarding dental health care are based on the professional expertise of the dentists and hygienists, and not on insurance benefits coverage.
- Marks Family Dentistry will file indemnity and PPO policies, but is not a participating provider with any insurance company. Any unpaid balance is the responsibility of the patient.
- Prior to treatment, it is the patient's responsibility to inform this office of any changes in my insurance policy or changes in my coverage within the same policy.

2. I authorize the release of medical information that may be pertinent to my dental care to any of my health care providers or insurance companies.

3. I authorize direct payment to Marks Family Dentistry of insurance benefits that are otherwise payable to me. If insurance payments are sent to me, I agree to notify Marks Family Dentistry immediately and to send the full amount to Marks Family Dentistry within five (5) business days.

PAYMENTS

4. I understand arrangements for payment must be established before dental services are provided. Payment options are: cash, check, money order, debit card or credit card. Special financing options may be available with approved credit.

5. I understand payment plans will carry a finance charge within the limits prescribed by Virginia law. In extended payment plans, a finance charge of 1 1/2% per month (18% APR) will be added after 60 days.

6. I authorize the disclosure of information regarding my relationship with this office to any party to whom disclosure is necessary to collect a fee for the services provided.

7. I understand that default on payment will subject the account to all collection fees, including, but not limited to court costs and 33.33% attorney fees or collection agency fees of the total outstanding indebtedness, (whether or not court proceedings are necessary), that may be incurred in enforcing Marks Family Dentistry's right under this agreement or under any law of the Commonwealth of Virginia.

CANCELLATION OF APPOINTMENTS OR FAILED APPOINTMENTS

8. I am aware that Marks Family Dentistry reserves the right to charge $50 per appointment hour for failed appointments and for appointments cancelled with less than 24 hours notice.

PRIVACY POLICY (HIPAA)

9. I acknowledge receipt of the Notice of Privacy Practices (HIPAA) for Marks Family Dentistry. .

PATIENT SIGNATURE

10. By signing below I certify that:

- I have completed the questions on my Patient Registration, my Medical History, and my Dental History truthfully and correctly.
- I have been given the opportunity to read and ask questions regarding: ♦ Insurance ♦ ♦ Payments ♦ Cancellation of Appointments or Failed Appointments ♦ Privacy Policy (HIPAA) ♦
- **I am aware that it is my responsibility to update Marks Family Dentistry, prior to treatment, of any change in my dental or medical condition or any change in medications, either prescription or over the counter**.
- I understand my acknowledgement of (a) the accuracy of the information I have provided and (b) the policies of Marks Family Dentistry are binding on current and future services provided by this office.

Patient's Name (Please Print)

Signature of Patient / Parent / Guardian

Date

Marks Family Dentistry
9150 Dickey Drive, Mechanicsville Virginia 23116
804-746-3336
www.MarksFamilyDentistry.com

Marks Family Dentistry

Dental History

Referred by: _____

How do you rate the condition of your mouth? O Excellent O Good O Fair O Poor

Previous Dentist: _____ How long were you a patient? _____Months/Years

Date of most recent dental exam: _____ Date of most recent dental x-rays: _____

Most recent treatment other than cleaning: _____ Date of treatment: _____

I routinely see my dentist every: O 3 months O 4 months O 6 months O 12 months O Not routinely

What is your immediate concern? _____

PERSONAL HISTORY

Y N 1. Are you fearful of dental treatment? On a scale of 1 (least)--10 (most), how fearful? 1 2 3 4 5 6 7 8 9 10

Y N 2. Have you had an unfavorable dental experience? _____

Y N 3. Have you ever had complications from past dental treatment? _____

Y N 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____

Y N 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ At what age? _____

Y N 6. Do you have missing teeth that never developed or were lost due to facial trauma, fractures, or cavities?
Describe: _____

SMILE CHARACTERISTICS

Y N 7. Is there anything about the appearance of your teeth that you would like to change? _____

Y N 8. Have you ever whitened (bleached) your teeth? _____

Y N 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____

Y N 10. Have you been disappointed with the appearance of previous dental work? _____

BITE AND JAW JOINT

Y N 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____

Y N 12. Do you have any problems chewing gum? _____

Y N 13. Do you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____

Y N 14. Have your teeth changed in the last 5 years, become shorter; thinner or worn? _____

Y N 15. Are your teeth crowding or developing spaces? _____

Y N 16. Do you need more than one bite or squeeze to make your teeth fit together? _____

Y N 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have other habits that damage teeth?

Y N 18. Do you clench your teeth in the daytime or make them sore? _____

Y N 19. Do you have any problems with sleep or wake up with headaches or an awareness of your teeth? _____

Y N 20. Do you wear or have you ever worn a bite appliance? _____

TOOTH STRUCTURE

Y N 21. Have you had any cavities within the past 3 years? _____

Y N 22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? __

Y N 23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____

Y N 24. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____

Y N 25. Do you have grooves or notches on your teeth near the gum line? _____

Y N 26. Have you ever had broken teeth, chipped teeth, a cracked filling or a toothache? _____

Y N 27. Do you get food caught between any teeth? _____

GUM AND BONE

Y N 28. Do your gums bleed when brushing or flossing? _____

Y N 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____

Y N 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____

Y N 31. Is there anyone with a history of periodontal disease in your family? _____

Y N 32. Have you ever experienced gum recession? _____

Y N 33. Have your teeth ever become loose (without an injury),or do you have difficulty eating an apple? _____

Y N 34. Have you experienced a burning sensation in your mouth, not related to your teeth? _____

_____ _____ ____/___/_____ 5 / 4 / 2017

Patient's Name (Please Print) Patient's Signature Date

Marks Family Dentistry

Medical History

Please Return This Form to Marks Family Dentistry

Patient's Name (print): _____ Preferred Name: _____ Birth Date: _____

Address _____ City _____ State ____ Zip _____

Name of Physician: _____ Specialty: _____

Date of most recent physical examination: _____ Purpose: _____

How do you rate your general health? O Excellent O Good O Fair O Poor

DO YOU HAVE OR HAVE YOU EVER HAD :

Y N 1. Hospitalization for illness / injury

Y N 2. An allergic reaction to: (PLEASE CIRCLE)
Acrylic / Fluoride / Latex / Sulfa / Local Anesthetic / Penicillin / Tetracycline / Erythromycin / Aspirin / Ibuprofen / Acetaminophen / Codeine / Metals (Nickel Gold--Silver--Other _____ Nuts / Fruit / Other _____

HEART PROBLEMS:

Y N 3. Heart problems or cardiac stent within the last 6 months

Y N 4. History of infective endocarditis

Y N 5. Artificial heart valve, repaired heart defect (PFO)

Y N 6. Pacemaker or implantable defibrillator

Y N 7. High or low blood pressure

BLOOD PROBLEMS:

Y N 8. Stroke (taking blood thinners)

Y N 9. Anemia or other blood disorder

Y N 10. Prolonged bleeding due to slight cut INR>3.5

Y N 11. High cholesterol or taking statin drugs

RESPITORY OR LUNG PROBLEMS:

Y N 12. Pneumonia, emphysema, shortness of breath, sarcoidosis

Y N 13. Asthma

Y N 14. Breathing or sleeping problems (Sinus / Snoring / Sleep Apnea)

LIVER OR KIDNEY PROBLEMS:

Y N 15. Hepatitis (Type _____)

Y N 16. Liver disease

Y N 17. Jaundice

Y N 18. Diabetes (HbA1c= _____

Y N 19. Kidney disease

BONE OR JOINT PROBLEMS:

Y N 20. Orthopedic implant (joint replacement)

Y N 21. Osteoporosis / Osteopenia

Y N 22. Arthritis

DIGESTIVE PROBLEMS:

Y N 23. Stomach or duodenal ulcer

Y N 24. Digestive or eating disorders (celiac disease, gastric reflux, bulimia, anorexia)

NEUROLOGICAL PROBLEMS:

Y N 25. Alzheimer's or Parkinson's

Y N 26. MS or Paralysis

Y N 27 ADD/ADHD, piron disease

CANCER:

Y N 28. Tumor or abnormal growth

Y N 29. Radiation therapy

Y N 30. Chemotherapy, immunosuppressive medication

OTHER:

Y N 31. Rheumatic or scarlet fever

Y N 32. Thyroid, parathyroid disease, calcium deficiency

Y N 33. Hormone deficiency

Y N 34. Chronic ear infection, tuberculosis, measles, chicken pox, shingles

Y N 35. Autoimmune Disease (Rheumatoid Arthritis / Lupus / Scleroderma / Sjogren's Syndome)

Y N 36. Glaucoma

Y N 37. Contact lenses

Y N 38. Head or neck injuries

Y N 39. Epilepsy, convulsions (seizures)

Y N 40. Fibromyalgia

Y N 41. Viral infections and cold sores

Y N 42. Any lumps or swelling in the mouth

Y N 43. Hives, skin rash, hay fever

Y N 44. STI / STD / HPV

Y N 45. HIV / AIDS

Y N 46. Psychiatric treatment

Y N 47. Antidepressant medication

Y N 48. Alcohol or recreational drug use

ARE YOU :

Y N 49. Aware of a change in your health in the last 24 hours (fever, chills, new cough, diarrhea)

Y N 50. Taking medication for weight management

Y N 51. Taking dietary supplements

Y N 52. Often exhausted or fatigued

Y N 53. Experiencing frequent headaches

Y N 54. A smoker, smoked previously or used smokeless tobacco

Y N 55. Taking birth control pills

Y N 56. Currently pregnant

Y N 57. Presently being treated for any other illnesses

_____

_____

------over------

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment

_____

_____

_____

All current medications, supplements, and /or vitamins--use an additional sheet, if needed.

Drug	Dosage	Purpose

_____ _____/_____/_____

Signature of Patient / Parent / Guardian Date

VERY IMPORTANT

Please advise us of any changes in your contact information, your medical history or any medication when changes occur.

Dentist's or Hygienist's Notes:

Entered the Patient's Dental Record: Date: _____ By: _____

Updated: _____ By: _____ Updated: _____ By: _____

Updated: _____ By: _____ Updated: _____ By: _____

Marks Family Dentistry

Norman J. Marks, D.D.S. **S. Aaron Marks, D.D.S.** **Brandon S. Marks, D.D.S.**
www.MarksFamilyDentistry.com
804-746-3336

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact:
Privacy Officer
9150 Dickey Drive, Mechanicsville, Virginia 23116

Effective Date: April 14, 2003 *Revised: January 1, 2019*

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI.
We will follow the terms outlined in this Notice.
We may change our Notice, at any time. Any changes will apply to all PHI.
Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: https://www.MarksFamilyDentistry.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Collection agencies
- Government agencies in order to assist with qualification of benefits

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES: ● Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills. ● Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you. ● Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice
will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. See "Complaints" at the end of this document.

You have the right to see and obtain a copy of your protected health information.
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.
You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception:
We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.
We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.
You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

- If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Privacy Officer
Marks Family Dentistry
9150 Dickey Dr,
Mechanicsville, VA 23116

- You may also complain to the United States Secretary of Health and Human Services, if you believe your privacy rights have been violated by us:

Department of Health and Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102

- If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on January 1, 2019

Marks Family Dentistry

Norman J. Marks, D.D.S. S. Aaron Marks, D.D.S. Brandon S. Marks, D.D.S.
9150 Dickey Drive, Mechanicsville, Virginia 23116
www.MarksFamilyDentistry.com
804-746-3336

Authorization for Release of Protected Health Information

The Following Are Approved to Receive PHI for:

_____
Print Name of Patient

Please Print

Persons Who Can Receive Your PHI	Phone Numbers or Email	Appointment Reminders	Lab Results	Treatment Notes or Records	Discuss Treatment
Primary Contact---- Normally You _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Name of Spouse or Significant Other _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Name of Other Person _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
Name of Other Person _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____

I acknowledge receipt of the Notice of Privacy Practices (HIPAA) for Marks Family Dentistry.

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

_____ _____ _____
Signature of Patient or Personal Representative *Print Name of Patient or Personal Representative* *Date*

* *Description of Personal Representative's Authority (attach necessary documentation)*

Marks Family Dentistry

Payment Options

Marks Family Dentistry requests that payment arrangements be established before your dental services are provided. Our business staff is available to discuss these options with you.

Call us at (804) 746-3336.

Dental treatment is an excellent investment in your health. We offer several options to help you manage the financial considerations.

- ✓ **A 5% discount is given for payment in full on the day of treatment.**
  The discount does not apply to an account with an outstanding balance unless the account is paid in full on the day of new treatment. In that case, the discount applies to services for the current day, not to the entire account balance.
- ✓ **On the day of service, payment may be made in the form of cash, check, debit card or credit card.**
  For your convenience, we accept Visa, Mastercard and Discover
- ✓ **If you have dental insurance, we will file your claims electronically. Your estimated co-insurance will be due on the day of service.**

Financing is available to qualified Marks Family Dentistry patients through CareCredit.

Three Ways to Apply for Care Credit

Written application—available at our office
Phone Care Credit at (800) 365-8295
Go online to www.CareCredit.com for full details

CareCredit Offers:

- ✓ **6 or 12-Month Interest-Free Financing**
  or
- ✓ **Extended Payment Period with 14.9% Interest Rate**

CareCredit Requires:

- ✓ Approval before services are performed
- ✓ Payments made as agreed, to avoid interest or finance charges
- ✓ Payments must be made directly to CareCredit by mail or online

We appreciate your business!
Thank you for choosing Marks Family Dentistry.

www.MarksFamilyDentistry.com

Revised: 4 / 27 / 2012

Marks Family Dentistry
Policy Regarding Dental Insurance

It is very important for you to understand significant aspects of your dental insurance.
Dental insurance is one of the most complicated and time consuming issues we face in a dental office. Policies vary widely in the benefits they provide, the procedures they cover, and the fees they allow.

1. **Your policy is a contract between you----your employer----your insurance company. Marks Family Dentistry has no control over your benefits.** As a courtesy to you, we research your benefits prior to treatment. Always inform us of any change in employment, policy provider, or coverage in your existing policy. Based on the best information we can obtain, we make every effort to help you maximize your benefits. However, as the result of incorrect information provided to our employees, unwillingness of the insurance companies to provide benefits information, or changes in coverage, waiting periods, employment or insurance company, we are not always able to get accurate information.

   Please be aware, it is ultimately your responsibility to know your benefits and comply with the restrictions of your policy. This is especially important in scheduling appointments that have time or utilization restrictions, such as dental cleanings. Please schedule your appointments carefully to avoid having your insurance company deny your benefits.

2. **The dentists and hygienists at Marks Family Dentistry recommend dental treatment based on their professional expertise.** Although the final decision about your care is always yours, at no time is our recommended treatment determined by the amount an insurance policy will pay for a patient's care. Our goal has always been to determine what is in the best interest of the long-term, overall health of our patients.

3. **Marks Family Dentistry is not a participating provider with any insurance company. This means patients are responsible for any unpaid dental care.**

We have found that being bound to the provisions of insurance contracts affects the quality of the care you receive. The benefits of your policy are determined by what your employer elects to provide as coverage. When the insurance company discounts fees to the extent that many do, it adversely affects the quality of the materials we can select, the quality of the outside dental labs we use, and even many modern procedures that produce a much better and more cost effective result for you and your family.

We file all indemnity and PPO insurance. We do not file HMO / DMO, or Medicaid.

This means we will:
- File claims for indemnity and PPO dental insurance policies
- Follow up with the company to help you get your maximum benefits
- Aggressively follow through to ensure you receive favorable determinations for coverage provided in your policy

We strive to keep dental fees affordable and provide all patients with the best care possible; we believe that gives you the best value in dental care.

Norman J. Marks, D.D.S. ● S. Aaron Marks, D.D.S. ● Brandon S. Marks, D.D.S.
9150 Dickey Drive ● Mechanicsville, VA 23116
Phone (804) 746-3336 ● Fax (804) 746-3577

Additional information about dental insurance is on our website
www.MarksFamilyDentistry.com

Revised 3 / 31 / 2013