BETHESDA TMJ
Comprehensive Facial and Dental Pain Treatment Center

WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to serve you properly, we will need the following information. **(Please print.)**
All information will be strictly confidential.

Patient's name | Birth date | Social Security Number | Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐

Residence Address | City | State | Zip | Home Phone

If Child, parent's name or guardian's name | Social Security Number | Cellular Phone

Name of Employer | Occupation | Driver's License Number

Business Address | City | State | Zip | Business Phone Ext

Person to Contact in Emergency | Home Phone | Work Phone | Relationship to Patient

Referred by | Address | City | State | Zip | Phone Number

Name of Dentist | Address | City | State | Zip | Phone Number

Name of Physician | Address | City | State | Zip | Phone Number

I authorize Bethesda TMJ to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third part payers/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to Bethesda TMJ insurance benefits otherwise payable to me if I have not already paid in full.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Patient, Parent, or Guardian Signature_____ Date_____

THE BETHESDA
TEMPOROMANDIBULAR JOINTAND IMPLANT CENTER

FINANCIAL POLICY

Because medical and dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role or force us to compromise the quality of care to our patients.

When your office visit is completed, the receptionist will provide you with a super bill to submit to your insurance company so that you can be reimbursed. A dental claim will be submitted to your dental insurance company for reimbursement as well.

We will answer any questions your insurance company may raise about diagnosis or treatment in an appropriate, timely manner, but it is important to understand that the legal contract is between you and your insurance company—we are not part of the relationship. We are unable to "force" an insurance company to fulfill its obligations to you. Please contact your insurance company to find out if a procedure will be covered under your particular policy.

Failure to continue treatment after lab work has been completed will result in a charge equal to ½ of the usual charge for the completed lab work.

We would appreciate your payment for services as you receive them. **Please note that all accounts with a balance after 30 days are subject to a finance charge of 1% per month.**

I understand that I am directly and personally responsible to BTMJFPTC for all bills and that this authorization is made solely for the additional protection of BTMJFPTC. I agree to be responsible for all expenses, including interest at 1% per month (12% per year), reasonable attorney fees and court costs incurred by BTMJFPTC in collection of monies due and owing by me. I also agree to waive the defense of the statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services are rendered.

Attention Medicare Patients: **We will no longer submit claims to Medicare due to the Opt Out contract. You will be expected to pay in full for all treatment at the time of service.**

Please keep your appointments! Contact the office if you need to reschedule your appointment so that others can use the time. **Failure to cancel your appointment without 24 hours notice will result in the usual charge.**

I have read, understand and accept the above financial policy. I acknowledge that I am ultimately responsible for the amounts due and owing under this agreement regardless of my representation or coverage.

Patient _____ Date _____ Witness _____

10215 Fernwood Road, Suite 601 · Bethesda, Maryland 20817 · Phone (301) 493-9500 · Fax: (301) 897-5571 · email: bethesdatmj@gmail.com