Julie A. Veerman, DDS, LLC

3909 Arctic Blvd Suite 205 | Anchorage AK 99503 | 907.336-8772 voice | 907.563.8533 fax | staff@akdentspa.com

Please provide insurance card(s) and picture ID

REGISTRATION FORM

The following confidential information is for our records only

Name _____ (_____)
Last First MI (Name you go by if different)

Date of Birth: _____ Age: _____ Marital Status: _____ Gender: _____

Social Security #: _____ Driver's License #: _____

Mailing Address: _____
City State Zip

E-Mail Address(For email confirmation):_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please check preferred contact phone number: Home _____ Work _____ Cell _____

Patient Employed by: _____ Occupation: _____

Spouse's Name: _____ Contact number: _____

_____
If patient is a minor: Father's Name Employer Phone

_____
If patient is a minor: Mother's Name Employer Phone

Is there anyone we can thank for referring you to our office? _____

Referrals: When Dr. Veerman recommends a need for a patient to see a specialist, she uses her professional opinion and expertise to send you to the most qualified specialist she is aware of to meet your dental needs. All patients have the right to choose their providers and patient requests will be observed. Please consult Dr. Veerman on your preferences at the time of referral.

Cancellations and Missed Appointments: If you are unable to keep your appointment, you need to contact our office one business day in advance. Failure to notify the front desk and confirm your cancellation with staff may result in a no show fee. No show fees are required to be paid prior to scheduling future appointments. For appointments with hygiene there will be $50 no show/late cancellation charge, and for appointments with the doctor there will be a $100 no show/late cancellation charge.

_____ _____
PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

Please read and sign our Financial Policy on the back of this form

Julie A. Veerman, DDS, LLC

Financial Policy

Thank you for choosing Dr. Julie Veerman. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, or Discover

- We offer a 5% courtesy accounting adjustment to patients who do not have insurance coverage and pay for their treatment with cash, check or credit card on date of service. Patients age 65 and older will receive an additional 2% courtesy adjustment.

- Care Credit- personal healthcare credit card- please ask for more information

Please note:

As a courtesy for patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees. Interest charges will be incurred on balances over 60 days in the amount of 10.5% annually with a $1.50 minimum monthly rebill fee.

The patient portion of your treatment is due at the time of service. This is an **estimate** of your portion and the final payment will be determined when we receive final payment from your insurance company. Treatment plans may change, and you will be responsible for the work actually done.

Insurance: In order to verify your insurance coverage, you must provide current insurance information and photo identification. It is not possible for Dr. Julie Veerman and staff to know the specific benefits of your plan. It is your responsibility to be aware or your coverage and to ensure that your bill is paid.

Insurance Release: I authorize Julie A. Veerman, DDS, LLC to furnish to my insurance company all information which they may request. I authorize payment to be made directly to Julie A. Veerman, DDS, LLC, but not to exceed the charges incurred.

Dr. Julie Veerman charges $50 for returned checks

Release of Records: We request you give us a signed Release of Records form to transfer records. Please allow two business days to process records requests.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Statement of Agreement: This patient agreement and the terms within it are effective for three years from the date of my signature or until the agreement is revised.

I hereby individually obligate myself to pay the account in accordance with the fees and terms of the Dentist.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)