Advanced Dentistry of Richmond
Ursula Klostermyer DDS, PhD
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Richmond, VA 23226
(804)282-7260

Patient Information:

Patient's Name:_____ Today's Date:_____
Male____ Female____ Single____ Married____ Divorced____ Widowed____
Date of Birth_____ SS#_____ DL#_____
Address_____
Email_____ Occupation_____
Home #_____ Work #_____ Cell #_____
Place of employment_____ Employer_____
Responsible party (__) same as above or _____ Relationship_____
Referred by:
Online____ Doctor_____ Patient_____ Family Member_____
Medical Emergency Contact_____ Phone #_____

Insurance Information

Primary	Secondary
Company Name_____	Company Name_____
Policy Holder_____	Policy Holder_____
Policy Holder's Date of Birth_____	Policy Holder's Date of Birth_____
Policy Holder's SSN_____	Policy Holder's SSN_____
Relationship to Patient_____	Relationship to Patient_____
ID #_____	ID#_____
Group #_____	Group#_____

Consent for Services/Authorization/Financial Responsibility

I am responsible for payment of services or estimated co-pays when services are rendered, unless prior financial arrangements have been made. As a courtesy to our patients, we will file your Insurance forms for you; however, our office does not participate with any particular insurance plan. I understand that my insurance policy is a contract between myself and the insurance company and Advanced Dentistry of Richmond(ADR) is not a party to that contract. I am ultimately responsible for unpaid balances on non-covered services. If my account is turned over for legal collection, I agree to pay all costs associated with collection, including attorney's fees. Patient balances that go unpaid for 30 days or more incur one or more of the following charges: A) Interest charges of 1.5% per month or 18% APR, B) Collections fees(up to 42% of the full balance), C) Legal fees for collection services. I am responsible for informing the office of all changes to my information and insurance prior to my appointment. I authorize ADR to release medical information to my insurance company, its agents or any third party for use in determining my benefits. I understand that the fee for a returned check is $30.

Short notice cancellations or missed appointments affect many people. Missed appointments increase our cost of providing dental care-costs that ultimately must be passed on to our patients. More importantly, missed appointments do not allow us the opportunity to offer the appointment time to other patients needing and wanting care. For these reasons, please respect our time and that of the other patients by giving us a minimum of 48 hours notice to cancel or reschedule an appointment. For rescheduled or missed dental appointments, where less than two days notice is given, a charge of $100. per hour of scheduled time may be made to your account. For rescheduled or missed dental hygiene appointments, where less than two days notice is given, a charge of $50. may be made to your account. We appreciate your understanding.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I also understand that this information will be held in the strictest confidence. All fees quoted are guaranteed for 30 days. I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient, or guardian_____Date_____