Anthony J. Hornaday, D.D.S.
Oral Surgery of Indiana
620 S. Tillotson Avenue ◆Muncie, IN 47304 ◆(765) 289-9705

Office Financial Policy

1. If the patient does not have insurance, full payment is required at the time of surgery.

2. If you are having a single tooth removed, the entire fee (which we will provide you with prior to your services) will be due the day of the extraction. We will file your insurance claim for you and will reimburse you if any payment is made by your insurance company.

3. If the patient does have insurance, we do require a percentage of the total fee to be paid at the time services are rendered which is an ESTIMATE of your out of pocket expense. There may be an additional amount due after your insurance pays.

4. We are not responsible for benefits quoted to us by your insurance company whether this was received over the phone or if we have received a written predetermination on your behalf. Insurance companies will not guarantee coverage and/or payment to us until they receive an actual claim; therefore, regardless of the information that was given to us by your insurance company, either verbally or in writing, you may still be responsible for the entire fee for your treatment charged by this office.

5. We will file claims to all insurance companies, however, the ONLY insurance companies that Dr. Hornaday is contracted with are Delta Dental Premier and Medicaid. Regardless of insurance coverage, the patient, or patient's legal guardian, is ultimately responsible for all fees charged by this office.

6. Sixty days will be allowed for your insurance company to process and pay your claim. If, after sixty days, no notice has been received from your insurance company, it is your responsibility to contact them directly and the entire balance is your responsibility at that time.

7. If your insurance requires a predetermination prior to the procedure, it is the patient's (or patient's legal guardian's/Power of Attorney's) responsibility to notify our office.

8. The parent (or legal guardian) that accompanies a minor to the office will be responsible for all fees charged. We cannot and will not contact someone who was not present in our office to ask for payment, such as in a divorce situation.

9. Should your account become past due, you will be responsible to pay all collection costs, including collection agency fees, attorney fees, and all court costs. These fees will be added to your balance and this new amount will be placed with our collection agency and become your responsibility to pay.

10. Please note that if any portion of your care is rendered at IU Health Ball Memorial Hospital (in-patient or out-patient), there will be separate charges from the hospital that may or may not be fully covered by your insurance. Dr. Hornaday is not financially affiliated with the hospital and is not responsible for and has no knowledge of these charges. It is your responsibility to check with your insurance to see what will or will not be covered.

11. This signature is on file as my authorization for the release of information necessary to process my claim and collect monies owed. I hereby authorize payment directly to Dr. Anthony Hornaday of the insurance benefits otherwise due me. I certify that I am the legal guardian and/or power of attorney of the patient listed on this form. I have read the above financial policy and agree to all of the terms therein.

Patient_____ Patient's Signature _____Date _____

Parent or Legal Guardian Signature _____Date _____

Witnessed By _____Date _____

Patient Information

Anthony J. Hornaday, D.D.S.
Oral Surgery of Indiana

Dr. Mr. Mrs. Ms. Miss _____
First Middle Last Nickname

Address: _____ City/State: _____ Zip: _____

Home Tel #: _____ Work Tel #: _____ Cell #: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Male Female Marital Status: Single Married Widowed Divorced

Soc Sec. #: _____ Pharmacy:_____

Employer: _____ Occupation: _____

Patient's **Dentist**: _____ **Physician**: _____ **Orthodontist**: _____

Who referred you to our office? Dentist Physician Orthodontist Friend _____ Other_____

Have you or any member of your family been a patient in our office before? Yes No When? (Year): _____

Who?: _____ Relationship to patient: _____

If patient is a full-time student, name of school: _____

Emergency Contact: _____ Daytime phone #: _____

Relationship to patient: _____

Person **Responsible for Payment (if different from above)**

Person Responsible for Payment: _____

Address: _____ City/State: _____ Zip: _____

DOB: _____/_____/_____ Soc Sec #: _____

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

I understand in signing this statement that I am financially responsible to Dr. Anthony J. Hornaday for all fees incurred and all costs of collection: including but not limited to service, collection, collection agency, and attorney fees.

If your insurance company does not pay your claim as expected, the responsible party is obligated for the balance of the account. I hereby authorize the insured's insurance company to pay directly to Dr. Anthony J. Hornaday any and all of the benefits otherwise payable to me or the patient.

Signature of Party Responsible for Payment: _____ Relationship to Patient: _____

Print Name: _____

DENTAL Insurance Coverage Information **(If you have additional coverage, please request an additional form)**

Primary Dental Insurance Name of Insurance Company**:** _____

Subscriber Name: _____ DOB: _____/_____/_____ Insured's Daytime Phone #: _____

Subscriber Address: _____Plan ID (If other than SS#): _____

Subscriber Soc Sec #: _____ Group #: _____ Employer Name: _____

Relationship to Patient: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

MEDICAL Insurance Coverage Information **(If you have additional coverage, please request an additional form)**

Primary Medical Insurance Name of Insurance Company: _____

Subscriber Name: _____ DOB: _____/_____/_____ Insured's Daytime Phone #: _____

Subscriber Address: _____Plan ID (If other than SS#): _____

Subscriber Soc Sec #: _____ Group #: _____ Employer Name: _____

Relationship to Patient: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

I certify all information is true, correct, and complete and authorize the release of health care information for the purpose of evaluating and administering claims for benefits. I authorize payment of medical/dental benefits to Dr. Hornaday and accept full financial responsibility regardless of insurance coverage. I also certify that I am the **legal guardian** of the patient listed on this form.

Signed: _____ _____ Date: _____
Patient or Legal Guardian Signature Relationship to Patient

Print Name: _____

Patient Information

Anthony J. Hornaday, D.D.S.
Oral Surgery of Indiana

Patient Name: _____
First Middle Last Nickname

Reason for today's office visit: _____

Height: _____ **Weight**: _____ **Age**: _____	**Yes**	**No**	**Notes**
Have there been any changes in your general health in the past year?.....>	[ ]	[ ]	
Are you under the care of a physician?.....>	[ ]	[ ]	
For what? _____			
Have you ever been hospitalized or undergone any surgery?.....>	[ ]	[ ]	
Please explain: _____			

Please indicate if you have ever had any of the following conditions:

	Yes	No	Notes		Yes	No	Notes
Heart Disease				Anemia			
Chest Pain				Bleeding Problems			
Heart Attack				Sickle Cell Anemia			
Bypass				Stomach Ulcer			
Angioplasty				HIV or AIDS			
Heart Murmur				Cancer or Tumors			
Mitral Valve Prolapse				Radiation/Chemotherapy			
Rheumatic Fever				Liver Disease			
High Blood Pressure				Hepatitis or Jaundice			
Artificial Heart Valve				Diabetes			
Pacemaker				Thyroid Disease			
Stroke				Kidney Disease			
Glaucoma				Arthritis			
Asthma				Artificial Joints			
Lung Disease				Seizures (epilepsy)			
Tuberculosis				Illicit (Illegal) Drug Use			
Shortness of Breath				Alcohol/Drug Abuse			
Swollen Ankles				Psychiatric Disorder			

	Yes	**No**
• Are you currently taking any drugs or medications?.....>	[ ]	[ ]
Please List: _____		
_____		
• Have you ever had any adverse reaction to local or general anesthetic?.....>	[ ]	[ ]
• Are you allergic to anything?.....>	[ ]	[ ]
Please List: _____		
• Have you ever been treated or are you taking medicine for osteoporosis?.....>	[ ]	[ ]
• Have you ever been prescribed any bisphosphonate medications such as:		
Fosamax, Aredia, Zometa, Actonel, Boniva?.....>	[ ]	[ ]
• Is this visit a result of an accident?.....>	[ ]	[ ]
If yes, date of accident and describe: _____		
_____		
• Do you smoke?.....>	[ ]	[ ]
• Women: Are you pregnant?.....>	[ ]	[ ]
Are you nursing?.....>	[ ]	[ ]
Do you take birth control?.....>	[ ]	[ ]
• Do you have any other medical conditions not listed above?.....>	[ ]	[ ]
Please List:_____		
_____		

I certify all above information is true, correct, and complete and authorize the release of health care information for the purpose of evaluating and administering claims for benefits. I authorize payment of medical/dental benefits to Dr. Hornaday and accept full financial responsibility regardless of insurance coverage. If I am not the patient listed on this form, I certify that I am the **legal guardian/health care representative** of the patient listed on this form and have legal authority to make healthcare decisions for this patient.

Signed: _____ _____ Date: _____
Patient or Legal Guardian Signature Relationship to Patient

Print Name: _____

Procedure Consent (cont.)

Regarding Exposing and Bracketing of Teeth:

- I understand that if a bracket is being placed on a tooth that it may be dislodged during orthodontic treatment requiring additional surgery to replace it. I also understand that the impacted tooth being uncovered and bracketed may not be able to be brought into place by the orthodontist and may require removal.

Regarding biopsies:

- If a biopsy is being performed, I understand that more than one procedure may be necessary in order to remove the entire lesion if it is not removed in its entirety during the first procedure.
- Some lesions have a high reoccurrence rate and yours may reoccur and require additional operations months to years after the original surgery.
- I understand that a scar may occur at the biopsy site requiring further care or surgery.
- I understand that the tissue being removed will be sent to an outside oral pathology laboratory for a microscopic diagnosis and that there will be a separate fee for their services.
- I understand that Dr. Hornaday cannot be held responsible for the diagnosis rendered by the oral pathologist and that he will inform me if further treatment is necessary.

Regarding Dental Implants:

- I understand incisions will be made inside my mouth for the purpose of placing one or more root form structures (implant) in my jaw to serve as anchors for a missing tooth or teeth or to stabilize a crown (cap), bridge, or denture. I acknowledge that Dr. Hornaday has explained the procedure, including the number and location of the incisions and the type of implant to be used. I understand that the crown, bridge, or denture that will later be attached to this implant will be made and attached by a general dentist or prosthodontist and that a separate charge will be made for that work by him or her. I acknowledge that the fee paid to Dr. Hornaday is for the placement of the implant and any bone grafting ONLY.
- I understand that the implant must heal for a period of time before it can be used and that a second minor surgery may be required to uncover the top of the implant. I give my consent for the uncovering of the implant(s) at a specified future time and that all the items contained within this consent will apply.
- No guarantee can be or has been given that the implant(s) will last for a specific time period. It has also been explained to me that once the implant is inserted, the entire treatment plan must be followed and completed on schedule. If this schedule is not carried out, the implant may fail. I have been made aware that smoking and vaping can will cause implants to fail. I am solely responsible for the costs incurred to remove and/or replace failed implants.

I understand no warranties or guaranties of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask questions. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment to keep my tooth/teeth rather than undergo surgical intervention. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Hornaday has proposed. I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily. If I am not the patient listed on this form, I certify that I am the legal guardian/health care representative of the patient listed on this form and have legal authority to make healthcare decisions for this patient.

Patient _____ Patient's Signature _____ Date_____

Parent/Legal Guardian/POA Signature _____ Printed _____Date _____

Witness Signature _____ Date _____

Anthony J. Hornaday, D.D.S.
Oral Surgery of Indiana

Information Regarding Pain Clinics/Contracts, Controlled Substances and Substance Abuse

Patient Name: _____
First Middle Last Nickname

Date of Birth: _____/_____/_____ Age: _____ Sex: Male Female

1. Are you currently, or have you ever been, under a pain contract?
If so, with whom?

2. Are you currently receiving narcotic medications (i.e. Ultram, Tramadol, Norco, Vicodin, Lortab, Lorcet, Hyrdocodone, Percocet, Oxycodone, OxyContin, MS Contin, Fentanyl, Fentanyl Patch, Morphine, Dilaudid...)?
If so, please list:

3. Are you currently being treated for, or have you ever been treated for, narcotic or any substance abuse?
If so, please explain:

4. Are you currently taking, or have you ever taken, medications such as Suboxone, Subutex, Methadone, or Vivitrol?
If so, please explain:

Please note that this office does routinely use INSPECT; an INSPECT report summarizes the controlled substances a patient has been prescribed, the quantity of medication, the date the medication was prescribed/filled, the practitioner who prescribed them, and the dispensing pharmacy where the patient obtained them.

Falsifying information regarding your controlled substance use and/or pain clinic/pain contract involvement can have adverse health effects leading to serious complications, hospitalization, and even death. **Falsifying this information or not being completely honest with regards to this information will result in cancellation of your appointment and permanent dismissal from this office and may also result in dismissal by your pain clinic/doctor and no further prescriptions being dispensed to you.**

Patient_____ Patient's Signature _____ Date _____

Parent or Legal Guardian Signature _____ Date _____

Witnessed By _____ Date _____

Anthony J. Hornaday, D.D.S.
Oral Surgery of Indiana
620 S. Tillotson Avenue ♦ Muncie, IN 47304 ♦ (765) 289-9705

Medical/Protected Health Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

[ ] I authorize the release of my medical and protected health information from Anthony J. Hornaday, D.D.S. including all medical records, diagnoses, examination/test results, treatment, appointment times and information, claims information, and fees charged.

This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: **[ ]** my home **[ ]** my work **[ ]** my cell Number: _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ___/____/_____

Acknowledgment of Receipt of Notice of Privacy Practices

Anthony J. Hornaday, D.D.S.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

_____

_____

_____

Medicare Private Contract
for the Patients of Anthony J. Hornaday, D.D.S.

This Medicare Private Contract ("Agreement") dated as of _____20___, ("Effective Date") is made by and between **Anthony J. Hornaday, D.D.S.**, ("Dr. Hornaday") whose principal office is located at 620 S. Tillotson Ave., Muncie, IN 47304, and _____, ("you" or "the beneficiary, or his or her legal representative,"), who resides at _____(your address).

1. **Explanation**. Dr. Hornaday is no longer a participating physician with Medicare under the Social Security Act. This document explains Dr. Hornaday's rights and obligations as your physician, and your rights and obligations as Dr. Hornaday's patient. This contract is specifically limited to the financial agreement between you and Dr. Hornaday and does not obligate you or Dr. Hornaday to a specific medical treatment. A change in the Social Security Act, effective January 1, 1998, permits physicians and their Medicare patients, or their legal representatives, to enter into private written contracts regarding benefits. Beneficiaries, or their legal representatives, and physicians who take advantage of these private written contracts are not allowed to submit claims to Medicare, or to expect payment from Medicare. This applies only when you have a written private contract with a physician. It does not apply for other physicians that you see, unless you enter into a similar contract with those physicians.

You are not required to enter into a private contract with Dr. Hornaday, or with any physician that does not participate in the Medicare program. If you wish to continue to have your medical services paid under your Part B Medicare coverage, do not sign this agreement and transfer your care to another physician that is participating in the Medicare Part B program.

2. **Beneficiary Status**. You are a beneficiary currently enrolled in Medicare Part B or a beneficiary that may become enrolled in Medicare in the future. If you are not currently a Medicare beneficiary, this Agreement is applicable to you only upon your enrollment in Medicare.

3. **Dr. Hornaday's Status**. Dr. Hornaday has not been excluded from providing Medicare services. Dr. Hornaday has personally decided not to participate in Medicare.

4. **Dr. Hornaday's Obligations**.

   a) Dr. Hornaday will provide medical treatment to you that you have agreed to receive.

   β) Dr. Hornaday will not submit any claims to Medicare for any items or medical services that he provides, even if they are covered by Medicare.

   χ) Dr. Hornaday will not execute this Agreement when you are facing a medical emergency or urgent health care situation.

   δ) Dr. Hornaday will provide you with a copy of this Agreement before he provides medical services to you.

   ε) If the Centers for Medicare and Medicaid Services ("CMS") request a copy of this document, Dr. Hornaday will provide a copy to CMS.

5. **Beneficiary Obligations**.

   a) The beneficiary, or his or her legal representative, agrees to be fully responsible for payment of all items or services furnished by Dr. Hornaday. The beneficiary, or his or her legal representative, understands that no Medicare reimbursement will be available for Dr. Hornaday's services or any items furnished by him.

   b) The beneficiary, or his or her legal representative, and Dr. Hornaday agree that limits under the Medicare program do not apply to amounts which Dr. Hornaday may charge the beneficiary, or his or her legal representative.

χ) The beneficiary, or his or her legal representative, agrees not to submit a claim to Medicare and agrees not to ask Dr. Hornaday to submit a claim to Medicare for services provided to the beneficiary.

d) The beneficiary, or his or her legal representative, understands that due to this private contract, Medicare payment will not be made for any items or services furnished by Dr. Hornaday. This applies to services which normally would be reimbursable under Medicare if this Agreement were not in place.

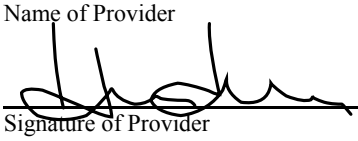
e) The beneficiary, or his or her legal representative, understands that this contract pertains to Dr. Hornaday's services only and that Medicare covered medical services may be obtained from other physicians who have not opted out of Medicare. This contract does not apply to relationships which the beneficiary, or his or her legal representative, has with other physicians.

f) Medigap plans under Section 1882 of the Social Security Act will not pay for services or items provided by Dr. Hornaday, since they are not covered by Medicare. It is also possible that other supplemental insurance plans may not pay for services or items provided by Dr. Hornaday, since they are not covered by Medicare.

6. **Term and Termination**. This document shall begin as of the Effective Date and be effective for one (1) year from the Effective Date (the "Initial Term"). **AT THE CONCLUSION OF THE INITIAL TERM OF THIS AGREEMENT, AND AT THE CONCLUSION OF EACH SUCCESSIVE RENEWAL TERM OF THIS AGREEMENT, THE TERM OF THIS AGREEMENT SHALL BE AUTOMATICALLY EXTENDED FOR ADDITIONAL ONE (1) YEAR PERIODS** (each, a "Renewal Term"). This Agreement shall automatically terminate upon the first to occur of the following: (1) Dr. Hornaday's election to participate in the Medicare program; (ii) in the event that Dr. Hornaday or the beneficiary, or his or her legal representative, violate any of the items set forth herein; or (iii) upon thirty (30) days prior written notice from one party to the other party; provided, however, that all amounts owned for items or services provided prior to the termination of this Agreement are the responsibility of the beneficiary, or his or her legal representative.

7. **Indemnification and Successors and Assigns**. The parties agree that this Agreement shall be fully binding upon their successors and assigns and that the beneficiary, or his or her legal representative, will indemnify and defend Dr. Hornaday against any claims, losses, liabilities or costs incurred as a result of any services provided to the beneficiary, or his or her legal representative, under this Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Effective Date first written above.

Anthony J. Hornaday, D.D.S. Name of Provider	Name of Beneficiary
 Signature of Provider	Signature of Beneficiary
620 S. Tillotson Ave., Muncie, IN 47304 Principal Office Address	Beneficiary's Legal Representative
1407897523 National Provider Identifier (NPI)	Beneficiary's Legal Representative's Signature