Lynn Pierri DDS, MS
Caring Without Compromise™

Date: ____/_____/_____

Patient Name: _____

Insurance Provider: _____

Insurance ID#: _____

I hereby instruct and direct the above named insurance providers to pay by check made out and mailed to Lynn Pierri, DDS, MS.

Or, if my current policy prohibits direct payment to Lynn Pierri, DDS, MS, I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O Lynn Pierri, DDS, MS
400 Townline Road, Ste, 135
Hauppauge, NY 11788

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize Lynn Pierri, DDS, MS to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at: 400 Townline Road, Hauppauge, NY 11788, this _____day of _____, 20____

_____ _____
Signature of Policyholder *(or guardian)* Witness

Lynn Pierri DDS, MS
Caring Without Compromise™

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Prepared for: _____

Dated: ____/_____/_____

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

_____
(Signature)

I, _____, give my permission for Dr. Lynn Pierri to
disclose results of all my test results and procedures to my: (*Check all that apply*)

□ Spouse □ Parents □ Children □ Leave message on home/cell phone

□ Other medical doctors, dentists, specialists or healthcare facilities
(Referring practitioners will automatically receive status reports)
Name & Address:

_____
(Signature)

For Office Use Only

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

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

Lynn Pierri DDS, MS
Caring Without Compromise™

Patient: _____

DOB: ____/____/_____

I have been clearly informed by the office of Dr. Lynn Pierri, DDS, MS, and understand the following in regards to my financial responsibility for I.V. Sedation and/or General Anesthesia administered by North American Partners in Anesthesia (N.A.P.A.):

- I will call my insurance company to see if my oral surgery procedure(s) is covered by my medical and/or dental insurance company. I understand the final determination of coverage is made by my insurance company(s) at such time that the claim is submitted.
- If the medical anesthesiologist used in this office does not participate with my medical/dental insurance plan(s), then I, or the responsible party, will be responsible for the anesthesia payment in full on the day of surgery.
- The final anesthesia fee will be determined by the length of time of my surgery which is to be determined by the anesthesiologist at the end of that surgery and is billed at the rate of $150.00 for the first fifteen (15) minutes, and $100.00 for each additional fifteen (15) minutes.
- I, and/or the responsible party, am solely responsible for submitting any claim(s) to my insurance plan(s) for possible reimbursement for anesthesia services using the statement given to me on the day of surgery with the appropriate codes and fees.
- Any reimbursement made by my medical/dental insurance plan(s) for anesthesia services will be made directly to me and any appeals process for reimbursement will be filed and followed by me.
- If the M.D. anesthesiologist does participate with my medical insurance plan(s); they will submit the claim on my behalf and I will be responsible for any fees, copayments and/or coinsurance payments as dictated under the terms and conditions of my insurance plan.

_____ _____

Patient Signature *(or guardian)* *(please print name)*

Date: _____

400 Townline Road, Ste. 135, Hauppauge, NY 11788 (631) 360-0266 Fax (631) 360-0087
www.lynnpierriddsms.com ● www.dentalimplantsoflongisland.com ● www.voxelimagingusa.com