Dr. Brian R. Topping, D.D.S, P.C.
Dr. Jeff A. Swihart, D.D.S.

102 W. Market Street
Nappanee, IN 46550
574-773-9700

220 Bloomingdale Dr. Suite B.
Bristol, IN 46507
574-848-7487

Patient Information

Referred By: ☐ Name of Friend/Relative__________ ☐ Newspaper ☐ Radio ☐ Television ☐ Outside sign ☐ Walk-in
☐ Homes Direct ☐ Phone Book

(If Responsible Party is same as Patient-write SAME)

Responsible Party____________________________ Date of Birth_______________S.S.#_________________
Address____________________________City____________________ State_____Zip_______________________
Telephone ______________Cellular #_____________________Work # ___________________________________
Place of Employment________________________________City_____________Zip_________________________
Spouses Name:______________________________

TREATMENT PLAN PRICES ARE GUARANTEED UP TO 30 DAYS FROM DIAGNOSIS DATE.

PRIMARY INSURANCE:
Insurance Subscriber Information: (**please present insurance card and photo I.D. for photocopy**)
Insurance Carrier __________________________________
Subscriber Name____________________________ Date of Birth_______________S.S.#_________________
Group Number_____________________________________Subscriber ID________________________________
Telephone______________Cellular#____________________Work#________________________________
Place of Employment________________________________City_____________Zip_______________________
Insurance telephone # ________________________________

*In Indiana, both parents are equally responsible for minor children. A divorce decree/support order is between those two parties – ***NOT THE PROVIDER*!**

SECONDARY INSURANCE:
Subscribers Name________________________Date of Birth______________S.S.#__________________
Insurance Carrier__________________________Address____________________City_________________
Telephone____________________Relationship to patient___________________
Group Number_____________________Insured ID#__________________________

*Non-duplication clause? We have recently noticed that many insurance carriers are imposing a non-duplication of benefits (carve out) "clause" for coordination of benefits on some employer group contracts. So, if the insurance carrier is the secondary carrier, the claim payment is determined as follows: "Payment is determined by deducting the primary carrier's payment from the procedure and then paying the additional amount after adjusting out the amount the primary paid. Usually, this results in no additional payment or a small amount of benefits paid out based on the contract fee schedule. Patients with dual coverage will often think that they have 100% coverage. Unfortunately, this is not the case with non-duplication clauses.

_______initial (if filing secondary insurance)

Topping Dental Group **Topping Family & Cosmetic Dentistry**

Patient Information

We will as a courtesy to our patients, file a claim with your insurance carrier. If you wish us to file, you will have to provide us with the subscribers date of birth, social security number, group number and name and address of where the claim is to be sent. By signing this form you are also authorizing payment of dental benefits to be paid to Dr. Brian R. Topping. You also understand that it is your responsibility to know exactly what your insurance plan will pay for in regards to any and all treatment. You also accept responsibilities for fees that exceed the payment amount made by your insurance company, if the Practice does not participate with your insurance company. You certify that the information on this sheet is true and correct to the best of your knowledge. You will also notify this office of any changes in status of the above information. However, responsibility for full payment of this account is yours. You, the patient or responsible parties of a minor, will be responsible for any costs incurred to collect any unpaid debt, including, but not limited to, Collection Fees, Interest Fees, and Attorney Fees. By signing this form you also agree to pay all co-payment, coinsurance, and deductibles or if not filing any insurance, payment in full, at the time all services are rendered.

FINANCIAL AGREEMENT The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to a collection agency or an attorney for collections, the undersigned will be required to pay reasonable attorney's fees and collection fees. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. ________ (initials)

____ ____________________

Signature of Patient or Guardian **Date**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ________________________, hereby authorize Dr. Brian R. Topping to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this content is voluntary, if I refuse to sign this consent, Dr. Brian R. Topping can refuse to treat me.

I have been informed that Dr. Brian R. Topping has prepared a ("Notice") which more fully describes the uses and disclosures that can be made of my individual identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Dr. Brian R. Topping, in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Brian R. Topping took before receiving revocation.

I understand that Dr. Brian R. Topping has reserved the right to change his privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Brian R. Topping restricts how my individual identifiable health information is used and/or disclosed to carry out treatment, payment or health operations.

I understand that Dr. Brian R. Topping does not have to agree to such restrictions, but that once such restrictions are agreed to, Dr. Brian R. Topping must adhere to such restrictions.
By signing below, I understand and have received the "Notice of Privacy Practices" and I give my consent for use and disclosure of any of my health information.

Signature of Patient or Guardian Printed Name Date

****Please sign below if you would like to receive email or text message reminders for upcoming appointments:**

✓ ___________________________________ : **EMAIL OR TEXT MESSAGE**
Signature

*****$35.00 NO SHOW/MISSED APPOINTMENT FEE will be added to your account if we do not receive a 2 business day notification for rescheduling appointments.**