Mark L. Glyman, M.D., D.D.S., F.A.C.S.
Eric D. Swanson, M.D., D.M.D., F.A.C.S.
825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708
Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Suite 150 • Las Vegas, NV 89134
Office (702) 507-5555 • Fax (702) 946-1300

Financial Policy

Dear Patient:

We would like to take this opportunity to thank you for choosing us as your health care provider. Our goal is to be devoted and available at all times to answer your questions and alleviate your concerns. We are dedicated to providing you with the most personalized and the highest quality of care. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to your treatment.

INSURANCE PATIENTS:

Prior to your scheduled visit we recommend that you verify your insurance benefits with your insurance company. Authorization or verification from your insurance carrier (written or verbal) is not a guarantee of payment. We will collect the required prepayment percentage, co-pay and deductible of the ***ESTIMATED*** charges at the time of treatment regardless of the assignment of benefits. The balance on your account is your responsibility whether the insurance company pays or not. We will bill your insurance company as a courtesy to you; therefore, we require that you supply us with all appropriate forms and information such as telephone numbers and addresses regarding your insurance company. In the event inaccurate information is obtained, making it impossible to bill the claim, the account will become your responsibility and payable in full within 30 days from the date of service.

Participating Provider Insurance Companies:
We accept most major insurance programs and participate in many local Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). All HMO patients cannot be seen without the proper referral. These have to be obtained from your Primary Care Physician (PCP). We will deduct any contractual discounts, if any, as stated by our contract with your insurance company. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

Non Participating Provider Insurance Companies:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. There is not contractual discount between our doctors and your insurance company. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If your insurance company pays below our fee schedule, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates. If you are dissatisfied with the benefits paid by your insurance you have the right to appeal to your insurance company for additional reimbursement.

SELF-PAY PATIENTS:

Full payment will be expected at the time of service. We accept Visa, MasterCard. Discover/Novus, check with proper identification and cash.

If any of these methods are not convenient for you, Care Credit, and independent credit company, can finance your care on approved credit. This will allow you to start your treatment today and make payments over time.

MINORS:

No minor will be seen without a parent or a legal guardian present. In the situation of a divorce, we will bill the insurance on file. If there are any balances due, the person signing the Financial Policy will ultimately be responsible for the balance.

We will charge a rebilling fee of 2% for each month on all unpaid balances over 30 days. Balances under $100.00 will be charged a minimum of $2.00 per month.

There will be a $25.00 service charge on all returned checks.

Please note: if your account is turned over to Transworld/Collections you will be charged a $20.00 processing fee.

Due to the personalized ordering process for dental implants there is a $400.00 deposit per implant. There will be a 20% restocking fee per implant for any cancelled dental implant procedure.

Please understand that payment of your bill is part of your treatment. We feel that the above explanations in regard to our policies will assure that we will preserve the best possible relationship with our patients. Please let us know if you have any questions or concerns. We would be more than happy to assist you.

I have read, understand and agree to the provisions of the Financial Policy.

Signature of Patient and/or
Person Financially Responsible

Date

Patient Copy

Mark L. Glyman, M.D., D.D.S., F.A.C.S.
Eric D. Swanson, M.D., D.M.D., F.A.C.S.
825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708
Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Suite 150 • Las Vegas, NV 89134
Office (702) 507-5555 • Fax (702) 946-1300

Financial Policy

Dear Patient:

We would like to take this opportunity to thank you for choosing us as your health care provider. Our goal is to be devoted and available at all times to answer your questions and alleviate your concerns. We are dedicated to providing you with the most personalized and the highest quality of care. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to your treatment.

INSURANCE PATIENTS:

Prior to your scheduled visit we recommend that you verify your insurance benefits with your insurance company. Authorization or verification from your insurance carrier (written or verbal) is not a guarantee of payment. We will collect the required prepayment percentage, co-pay and deductible of the ***ESTIMATED*** charges at the time of treatment regardless of the assignment of benefits. The balance on your account is your responsibility whether the insurance company pays or not. We will bill your insurance company as a courtesy to you; therefore, we require that you supply us with all appropriate forms and information such as telephone numbers and addresses regarding your insurance company. In the event inaccurate information is obtained, making it impossible to bill the claim, the account will become your responsibility and payable in full within 30 days from the date of service.

Participating Provider Insurance Companies:
We accept most major insurance programs and participate in many local Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). All HMO patients cannot be seen without the proper referral. These have to be obtained from your Primary Care Physician (PCP). We will deduct any contractual discounts, if any, as stated by our contract with your insurance company. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

Non Participating Provider Insurance Companies:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. There is not contractual discount between our doctors and your insurance company. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If your insurance company pays below our fee schedule, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates. If you are dissatisfied with the benefits paid by your insurance you have the right to appeal to your insurance company for additional reimbursement.

SELF-PAY PATIENTS:

Full payment will be expected at the time of service. We accept Visa, MasterCard. Discover/Novus, check with proper identification and cash.

If any of these methods are not convenient for you, Care Credit, and independent credit company, can finance your care on approved credit. This will allow you to start your treatment today and make payments over time.

MINORS:

No minor will be seen without a parent or a legal guardian present. In the situation of a divorce, we will bill the insurance on file. If there are any balances due, the person signing the Financial Policy will ultimately be responsible for the balance.

We will charge a rebilling fee of 2% for each month on all unpaid balances over 30 days. Balances under $100.00 will be charged a minimum of $2.00 per month.

There will be a $25.00 service charge on all returned checks.

Please note: if your account is turned over to Transworld/Collections you will be charged a $20.00 processing fee.

Due to the personalized ordering process for dental implants there is a $400.00 deposit per implant. There will be a 20% restocking fee per implant for any cancelled dental implant procedure.

Please understand that payment of your bill is part of your treatment. We feel that the above explanations in regard to our policies will assure that we will preserve the best possible relationship with our patients. Please let us know if you have any questions or concerns. We would be more than happy to assist you.

I have read, understand and agree to the provisions of the Financial Policy.

Signature of Patient and/or
Person Financially Responsible

Date

Office Copy

Mark L. Glyman, M.D., D.D.S.
Eric D. Swanson, M.D., D.M.D.

825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708 • Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Ste. 150 • Las Vegas, NV 89134 • Office (702) 507-5555 • Fax (702) 946-1300

PATIENT INFORMATION

Home Phone ____________ Today's Date ____________

Name ______________________________ Soc. Sec. # ____________
Last Name First Name Middle Initial

Address ____

City ______________________ State ____________ Zip ________

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Sex: ❑ M ❑ F Age ____ Birthdate ____________

Reason for today's visit? ____

Patient Employed By ______________________ Occupation ____________

Business Address ______________________ Business Phone ____________
Okay to call work? Y ❑ N ❑

Who should we thank for your referral? ____

In case of emergency, who should be notified? ______________________ Phone ____________
Name Relationship

Primary Physician ______________________ Phone ____________

Address ____

Dentist ______________________ Phone ____________

Address ____

PRIMARY INSURANCE

Insurance Company ____
Name Address Phone

Contact # ____________ Group # ____________ Member # ____________

Name of Insured ____
Last Name First Name Middle Initial

Relation to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address (if different from patient) ______________________ Phone ____________

City ______________________ State ____________ Zip ________

Person insured employed by ______________________ Occupation ____________

Business Address ______________________ Business Phone ____________
Okay to call work? Y ❑ N ❑

Does this insurance cover: Medical: ❑ Y ❑ N Dental: ❑ Y ❑ N Both: ❑ Y ❑ N

If your insurance does not cover ***both*** *medical and dental benefits, please provide insurance information for your separate dental or medical plan on the next page.*

Please continue on back of form.

Insurance Company ____
Name Address Phone

Contact # ____________ Group # ____________ Member # ____________

Name of Insured ____
Last Name First Name Middle Initial

Relation to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Does this insurance cover: Medical: ❑ Y ❑ N Dental: ❑ Y ❑ N

SECONDARY INSURANCE

Is patient covered by additional insurance? ❑ Y ❑ N

Insured Name ____________ Relation to Patient ____________ Birthdate ____________

Address (if different from patient) ______________________________ Phone ____________

Member's Employer ____________ Occupation ____________ Business Phone ____________

Okay to call work? Y ❑ N ❑

Insurance Company ____
Name Address Phone

Contact # ____________ Group # ____________ Member # ____________

Does this insurance cover: Medical: ❑ Y ❑ N Dental: ❑ Y ❑ N Both: ❑ Y ❑ N

ACCIDENT RELATED INJURIES

Is this visit related to an Accident? Auto: ❑ Y ❑ N Work Related: ❑ Y ❑ N Other: ❑ Y ❑ N

Date of Injury ____________ Insurance Company ______________________ Phone ____________

Claim # ____________ Name of Case Worker/Adjuster ______________________

Name of Attorney ______________________________ Phone ____________

Please Read and Sign Below and Return Form to Receptionist

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________
Name of the Insurance Company(ies)

and assign directly to Dr.____________ insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature Relationship Date

Approved by:
Date:

Mark L. Glyman, M.D., D.D.S.
Eric D. Swanson, M.D., D.M.D.
825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708 • Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Ste. 150 • Las Vegas, NV 89134 • Office (702) 507-5555 • Fax (702) 946-1300

MEDICAL HISTORY

(Please Print)

Please answer the following questions.

Patient Name ____
Last Name First Name Middle Initial

Are you in good health? Y ❑ N ❑ Height__________ Weight__________

Have there been any changes in your general health in the past year? Y ❑ N ❑

If so, for what are you being treated?______________________________

Have you had any illness, operation or been hospitalized in the past five years? Y ❑ N ❑

Do you have any unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where.______________________________

Do you have a prosthetic joint/implant? Y ❑ N ❑ If so, describe where. ______________________________

Have you had a heart valve replacement or vascular graft? Y ❑ N ❑

Have you ever been diagnosed with HIV/AIDS? Y ❑ N ❑

Are you claustrophobic? Y ❑ N ❑

	Have You Had Or Do You Currently Have:	Yes	No		Have You Had Or Do You Currently Have:	Yes	No
1	Rheumatic Fever			28	Stroke		
2	Damaged Heart Valves/Mitral Valve Prolapse			29	Thyroid Trouble		
3	Heart Murmur			30	Diabetes		
4	High Blood Pressure			31	Low Blood Sugar		
5	Low Blood Pressure			32	Kidney Trouble		
6	Chest Pain, Angina			33	Are You On Dialysis		
7	Heart Attack(s)			34	Swollen Ankles, Arthritis Or Joint Disease		
8	Irregular Heart Beat			35	Stomach Ulcers		
9	Cardiac Pacemaker			36	Contagious Diseases		
10	Heart Surgery			37	Sexually Transmitted Diseases		
11	Bronchitis, Chronic Cough			38	Problems With The Immune System		
12	Asthma			39	Delay In Healing		
13	Hay Fever/Sinus Problems			40	A Tumor Or Growth		
14	Tuberculosis			41	X-ray Treatment/Chemotherapy		
15	Persistent Cough			42	Bloody Sputum		
16	Unexplained Weight Loss			43	Fever		
17	Emphysema			44	Chronic Fatigue/Night Sweats		
18	Difficult Breathing/Other Lung Trouble			45	Are You On A Diet		
19	Do You Smoke			46	A History Of Drug Abuse		
20	Blood Transfusion			47	A History Of Alcohol Abuse		
21	Blood Disorder Such As Anemia			48	Contact Lenses		

Please continue on second page

		Yes	No			Yes	No
22	Bruise Easily			49	Eye Disease/Glaucoma		
23	Bleeding Tendency (Abnormal Bleeding)			50	Mental Health Problems		
24	Jaundice Hepatitis Or Liver Disease			51	A Removable Dental Appliance		
25	Infectious Mononucleosis			52	Pain & Clicking Of Jaws When Eating		
26	Gallbladder Trouble			53	Malignant Hyperthermia		
27	Fainting Spells			54	Convulsions, Epilepsy		

If you are having surgery today, please answer the next two questions

55	Have you had anything to eat or drink in the last 8 hours? Y ❑ N ❑	56	Who is driving you home today?____________________

MEDICATION

Are You Now Taking:		Yes	No	62	Any Other Medications? If Yes, Please List Below:
57	Any Kind Of Medicine, Drugs, Or Pills				
58	Anticoagulants				
59	Diet Pills				
60	Tranquilizers				
61	Steroids				

ALLERGIES

Are You Allergic To Or Had A Reaction To:		Yes	No	Are You Allergic To Or Had A Reaction To:		Yes	No
63	Local Anesthetics			68	Codeine Or Other Narcotics		
64	Penicillin			69	Other Medications		
65	Other Antibiotics			70	Allergies Other Than Drug Allergies? (Please List Below):		
66	Sodium Pentothal, Valium, Or Other Tranquilizers						
67	Aspirin						

WOMEN

Please Answer The Following:		Yes	No	Please Answer The Following:		Yes	No
71	Is There A Possibility Of Pregnancy?			73	Are You Nursing?		
72	Estimated Delivery Date ____/____/____			74	Are You Taking Birth Control Pills?		

FAMILY HISTORY

Is There A Family History Of:		Yes	No	Is There A Family History Of:		Yes	No
75	Cancer			78	Diabetes		
76	Heart Disease			79	Anesthetic Problems		

77 Is there any condition concerning your health that the doctor should know about?

Please Describe:

I certify that I have read and understand all the questions answered above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

____

Patient Signature (Guardian if Minor) Date

Physician Signature: ______________________________ Date: __________

Mark L. Glyman, M.D., D.D.S.
Eric D. Swanson, M.D., D.M.D.
825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708 • Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Ste. 150 • Las Vegas, NV 89134 • Office (702) 507-5555 • Fax (702) 946-1300

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ______ day of ______________, 20____.

Print Patient Name: ____

Relationship to Patient: ____

Signature: ____

Mark L. Glyman, M.D., D.D.S.
Eric D. Swanson, M.D., D.M.D.
825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708 • Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Ste. 150 • Las Vegas, NV 89134 • Office (702) 507-5555 • Fax (702) 946-1300

CONFIDENTIALITY FORM

Please understand that it is the goal of this office to ensure that our patient's privacy is held in the strictest of confidence. Please carefully read the following information.

The purpose for this form is to give authorization to family, friends or legal guardian to discuss your medical/surgical status, such as: date of service, medications, complications, diagnostic testing or any questions to assist in your care and treatment.

Much of the information will be by telephone conversation with the doctor, nurse, front office personnel or surgery-scheduling department. Authorized persons will be required to have a "CODE" number. The code number will be the last four digits of your social security number. If the person inquiring about you does not have the "CODE" number no information will be released by telephone, fax or mail.

Please list name(s) and relationships of ALL persons authorized. If no person is to be given this information then write "ALL PERSONS DENIED". For your security, failure to provide any information or providing incomplete information will constitute "all persons denied." Thank you.

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

______________________________ ______________
Patients/Guardian Signature Date

______________________________ ______________
Patients/Guardian Signature Date

MARK L. GLYMAN MD DDS FACS*
ERIC D. SWANSON MD DMD FACS*

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES OF NEVADA

UPDATED/CURRENT INFORMATION FOR APPOINTMENT CONFIRMATION

PATIENT NAME: ______________________________

PATIENT DOB: ______________________________

PATIENT CELL PHONE NUMBER: ______________________________

PATIENT E-MAIL ADDRESS: ______________________________

WWW.FACIALSURGERY.ORG

825 N. GIBSON, SUITE 441
HENDERSON, NV 89011-1708

P 702.892.0833
F 702.892.0906

1775 VILLAGE CENTER CIRCLE #150
LAS VEGAS, NV 89134

P 702.507.5555
F 702.946.1300

*Diplomate American Board of Oral and Maxillofacial Surgery
*Fellow American College of Surgeons

Mark L. Glyman, M.D., D.D.S.
Eric D. Swanson, M.D., D.M.D.
825 N. Gibson, Ste. 441 • Henderson, NV 89011-1708 • Office (702) 892-0833 • Fax (702) 892-0906
1775 Village Center Circle, Ste. 150 • Las Vegas, NV 89134 • Office (702) 507-5555 • Fax (702) 946-1300

PATIENT PHARMACY INFORMATION

We are utilizing Electronic Prescribing for prescriptions whenever possible.

We need your pharmacy information to update our system. Please fill out the information below:

Patient Last Name: ______________________ First Name: ________________ Middle Initial: _____

Date of Birth: ______________________

Local Pharmacy Name: ____

Pharmacy Phone Number: ____

Pharmacy Address: ____
(If not known, please give major cross streets e.g. "Walgreens at Main and Washington")