1179 E Paris Ave SE, Suite 130
Grand Rapids, MI 49546-3682
Phone: (616) 226-1370 : Fax: (616) 327-6370
Email: michigan@carepointanesthesia.com
https://cpmich.com

DUAL INSURANCE POLICY AGREEMENT
(with Healthy Kids Plan)

For (Child's Name): _____ ***Scheduled Appointment:*** _____

The **CarePoint Dental Anesthesia Group of Michigan PLLC,** herein after known as "CarePoint", is dedicated to providing specialized anesthesia services to the familiar and comfortable environment of your dentist's office, bringing a tailored and personal touch to your child's care.

We understand that many patients have more than one insurance policy. Because multiple insurances require different processing guidelines, we would like to inform you of CarePoint's Dual Insurance Policy as stated below. Please initial below that you have read, understood, and acknowledge this Dual Insurance Policy Agreement.

_____ For claims processing purposes, this Dual Insurance Policy Agreement and the Dual Insurance Information Form (following page) ***must be completed and received by CarePoint prior*** to your child's scheduled appointment.

_____ CarePoint is not in-network with any private insurance companies.

_____ CarePoint is a separate entity from your dentist and that all related fees, operative times and/or dental procedures are billed separately.

_____ Since CarePoint is out-of-network with ***ALL*** private insurance companies, they will oftentimes deny the claim and will mail the copy of the Explanation of Benefits ("EOB") to you directly. Please provide us with a copy, as it is required by Healthy Kids of Michigan (BCBS or Delta Dental) for it to be part of the supporting documentation when we submit our claim to them for processing.

_____ I understand that I would be held financially responsible for the dental anesthesia service provided by CarePoint, should I not forward the required copy of the EOB in a timely manner.

_____ Having insurance benefit(s) does not guarantee payment of the dental anesthesia service. I understand that it would be my financial responsibility should the insurance not pay for the service.

ACKNOWLEDGEMENT

I, the undersigned, certify that I have read, understood, and acknowledge that I have retained a copy of this Dual Insurance Policy Agreement. I also understand and acknowledge my financial responsibilities for the dental anesthesia services provided by CarePoint, should the claims submitted by CarePoint be denied by both of my private and Healthy Kids of Michigan insurances.

Signature: _____ Relationship: _____ Date: _____
Parent/Legal Guardian to Patient

Dual Insurance Information Form

(Please complete this form in its entirety to prevent any delay in the PRIMARY claim's submission process.)

PRIMARY Dental Insurance

Name of Insured: _____ DOB: _____

Subscriber's ID# or SSN: _____ Employed By: _____

Insurance Carrier Name: _____ Group# or Policy#: _____

Address of Insurance Company: _____

SECONDARY Dental Insurance **(If Healthy Kids, please skip and complete the next section.)**

Name of Insured: _____ DOB: _____

Subscriber's ID# or SSN: _____ Employed By: _____

Insurance Carrier Name: _____ Group# or Policy#: _____

Address of Insurance Company: _____

Healthy Kids of Michigan

Select One: [ ] **BCBS ID**# _____ [ ] **Delta Dental** ID# _____

Patient Name: _____ Date of Birth**:** _____

Additional Information**:** _____

ACKNOWLEDGEMENT

I, the undersigned, do hereby authorize the release of information including the diagnosis and the records of the dental anesthesia treatment rendered to my child during the period of such dental care to third party payors, health practitioners or as required by law.

Signature: _____ Relationship: _____ Date: _____
Primary Subscriber to Patient

CarePoint
ANESTHESIA GROUP
A COMFORTABLE WAY TO A HEALTHY SMILE

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NEW PATIENT INTAKE FORM
(with Healthy Kids Dental Program)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: M [ ] F [ ] Weight (lbs.): _____ Height: _____

Healthy Kids of Michigan: **BCBS ID#**_____ **Delta Dental ID#**_____

Dental Office Name: _____ Contact Number: _____

Dental Office Address: _____

Primary Physician Name: _____ Contact Number: _____

(If applicable) Specialist Physician Name: _____ Contact Number: _____

PARENT OR LEGAL GUARDIAN INFORMATION

Please check one.

Mother [ ] **Father** [ ] **Legal Guardian** [ ] **Other**: _____

Full Name: _____ Date of Birth: _____ Contact Number: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Email Address: _____

PREGNANCY/NEONATAL HISTORY

1. Were there any complications during pregnancy or delivery? [ ] NO [ ] YES, reason(s): _____
   _____
2. Delivery: [ ] VAGINAL [ ] C-SECTION, reason(s): _____
3. Was your child premature? [ ] NO [ ] YES, born at number of weeks _____
4. Were there any complications during the newborn period? _____
   _____
   _____
   _____

INFANCY/CHILDHOOD/ADOLESCENCE HISTORY

1. Does your child have any allergies to drugs, supplements, or latex? [ ] NO [ ] YES, please select type of reaction(s): [ ] Rash [ ] Hives [ ] Emergency Room [ ] Other: _____
2. Has your child ever been hospitalized? [ ] NO [ ] YES, reason? _____

3. Has your child ever had surgery? [ ] NO [ ] YES, reason? _____
4. Has your child ever had general anesthesia? [ ] NO [ ] YES If so, any problems with anesthesia?

   _____
5. Has anyone in your family had problems with general anesthesia? [ ] NO [ ] YES If so, what problems?

   _____
6. Has your child ever been treated for or diagnosed with any of the following conditions?

	YES	NO	WHEN	MEDICINE / TREATMENT
Heart Diseases				
* Heart Murmur				
* High Blood Pressure				
* Irregular Heart Beat				
* Congenital Heart Defect				
* Other Heart Problems				
Lung Diseases:				
* Wheezing / Bronchiolitis				
* Asthma				
* Pneumonia				
* Obstructive Sleep Apnea				
* Other Lung Problems				
Other Medical Conditions:				
* Diabetes				
* Kidney Disease				
* Seasonal Allergies / Eczema				
* GERD / Ulcer / Hernia				
* Recurrent Ear Infection				
* Seizure Disorder				
* Psychiatric Condition				
* Genetic Syndrome				
* Learning Disability				
* Anemia				

Please list any other medical conditions: _____

_____

_____

_____

*** PRE-OPERATIVE GUIDELINES ***

- Nothing to eat after midnight (this includes gum, candy, or anything other than clear liquids)
- Clear liquids (i.e., water, apple juice, Gatorade, 7-Up, or Sprite) can be consumed after midnight, but they must be stopped four (4) hours before the appointment time that was provided to you by the dental office.

*** IMPORTANT NOTIFICATION ***

A Parent or a Legal Guardian must be present and remain at the dental office during the time of service.

HIPAA AND OUR PRIVACY POLICIES

(The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") addresses the manner in which a Patient's individual health information may be used or disclosed by Covered Entities (as defined in HIPAA) and other individuals and entities, such as a Provider. For more information regarding your rights under HIPAA, please visit their site at https://hhs.gov/ocr/privacy.)

Please initial below that you have read, understood, and acknowledge the following:

— I give CarePoint permission to communicate with me via email, text messaging, and to my cellular devices.

— I understand that I have the option of accessing and/or viewing the Notice of Privacy Practices online at https://cpmich.com or have a printed copy provided to me.

— If needed, I hereby request and give my authorization to my child's medical providers to release his/her medical history records to CarePoint. I also understand that I can revoke this permission at any time.

— I understand that I am giving my permission to CarePoint the use and disclosure of my child's protected health information in order to carry out the dental anesthesia treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke this permission at any time.

ACKNOWLEDGEMENT

I, the undersigned, certify that I have read the above pre-operative guidelines and that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my child's treatment and treatment results.

Signature: _____ Relationship: _____ Date: _____
Parent/Legal Guardian to Patient

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CONSENT FOR DENTAL ANESTHESIA SERVICES

The following is provided to inform patients about having treatment under dental anesthesia. The information is not presented to make you more apprehensive, but rather to enable you to better understand the risks and benefits involved with anesthetic treatments.

For (Child's Name): _____ ***Scheduled Appointment***: _____

I, the undersigned, hereby authorize and request any doctor represented with CarePoint Dental Anesthesia to administer anesthesia to my child as previously discussed with me. I understand and agree that procedures not talked about, but deemed necessary for my child's well-being may be performed to supplement the planned anesthesia. It has been explained to me that all types of anesthesia, although safe, involve some risks and no guarantees can be made concerning results. Serious complications are very rare. The following are complications that may be associated with the anesthetic treatment:

Common Complications:
- Pain and/or bruising at the IV site
- Sore throat and/or hoarseness
- Muscle aches
- Nausea and/or vomiting

Rare Complications:
- Heart injury
- Brain damage or death

Uncommon Complications:
- Headaches
- Injuries to lips, teeth, mouth or throat from airway instruments or devices
- Unexpected drug reaction
- Infection at intravenous site and veins nearby
- Bleeding/injury in the nose due to passage of a breathing tube
- Lung infection
- Eye injury or infection
- Weakness in breathing after awakening
- Nerve Damage

- Alternative options to deep sedation/general anesthesia have been discussed with me and may include the use of local anesthesia with nitrous oxide sedation or local anesthesia alone.
- I confirm that my child (the patient) has not had anything to eat or drink after midnight (this includes gum, candy, or anything other than clear liquids). Clear liquids (i.e., water, apple juice, Gatorade, 7-Up, or Sprite) can be consumed after midnight, but they must be stopped four (4) hours before the appointment time that was provided to you by the dental office.
- I certify that to my knowledge that my child (the patient) is not pregnant or trying to become pregnant.
- I have read and agree to the HIPAA Notice of Privacy Practices posted on our website www.cpmich.com.

ACKNOWLEDGEMENT

I, the undersigned, consent to the anesthesia deemed appropriate by my child's anesthesiologist. I acknowledge that I have read this form or had it read to me and that I understand the risks, alternatives, and expected results of the anesthetic plan of care.

Signature: _____ Relationship: _____ Date: _____
Parent/Legal Guardian to Patient