ADMINISTRATIVE AND FINANCIAL POLICIES

Welcome to our practice! Please take a few moments to review our office policies to help you feel as comfortable and informed as possible. These policies have been established to assure the financial resources needed to provide high-quality care.

Payment for dental service is due and payable at the time of service. We accept cash, check, debit card, Visa, MasterCard, American Express, Discover, and Care Credit. For extensive treatment plans, our office may request a partial down payment prior to scheduling.

For patients WITH dental insurance:
If you have dental insurance benefits, please provide your current insurance card. We will submit your dental insurance claim for you as a courtesy. We collect payment of your estimated portion at the time of the service. The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay. The insurance company will make the final determination once the claim has been processed. Please keep in mind:

- Your dental insurance is a contract between you and the dental insurance company. Therefore, the patient or guardian is responsible for the bill, regardless of the insurance coverage.
- Dental insurance is meant to serve as an aid, not to cover all expenses. Not all services are a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
- Waiting periods, copayments, deductibles, exclusions, and contract limitations may be present in your dental insurance plan. You are responsible to know of any such exclusion. We encourage you to contact your insurance company directly to understand your dental insurance benefits.
- Insured patients are expected to pay the estimated co-payment or non-insurance payments and deductibles at the time of service
- We expect all insurance payments within 30 to 45 days. We closely monitor and follow up on all insurance claims. After 60 days if your insurance company has not reimbursed our office you will become responsible for the balance. Balances not paid within this time will be assessed a finance fee of 18% per annum or 1% per month. Balances not paid within 90 days may be subject to collection.

For patients WITHOUT dental insurance:
If you are ***uninsured*****,** we offer a 10% discount for payment in full by CASH or CHECK only. Payment by credit card does not qualify to receive the 10% discount.

Cancellation/Failure Policy:
If you need to cancel or reschedule your appointment, please contact our office at least *48 hours* prior to the scheduled appointment. A fee of $50 could be charged if an appointment is cancelled or missed with less than 48 hours' notice.

Returned Checks:
Any check returned from the bank for "insufficient funds" will result in a $20.00 charge on your account. If a check is returned for insufficient funds it may be re-presented electronically to your bank, and you will be assessed an additional processing fee of $20.

I certify that I have read and fully understand the policies of this office.

Patient Signature:____ Date:______________

PATIENT CONSENT FORM - HIPPA

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 this practice to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- Discussing my treatment with guardians or care givers when necessary

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

I understand that I have the right to request restrictions on my protected health information and how it is used. I acknowledge that the healthcare provider may not agree or consent to these restrictions and that they must be requested in writing.

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.

Print Patient Name: ____________________________________ Relationship to Patient: ___________________

Signature: ____ Date: _________________