# Financial Policy Acknowledgment

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment plans. Check policy: If you check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $35.

We will communicate all recommended treatments option and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee $25. Should you find it necessary to reschedule an appointment, please provide us with a notice of two business days to avoid being charged a missed appointment fee.

As a courtesy to you, we will be happy to bill your insurance company and work with you to maximize your benefits. Please remember that the financial obligation for your dental treatment is between you and this office. All outstanding balance not paid by the due date will incur a monthly finance charge with 14.99% interest. Outstanding balances over 90 days will be forwarded to an outside agency for collection. These accounts will be subject to a collection fee of up to, but not limited to 35%. No question is too small for you to ask, whether it is about your treatment, benefit or statement. We are here to help you.

My signature indicates that I have read and understand the above information.

Patient/Parent/Guardian Signature_____Date:_____

# Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of privacy practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____