Financial and Insurance Policy

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at time of service

There is a $35.00 processing charge for non-sufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 90 days, I agree to pay the full remaining balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office in accordance with its credit terms and policy.

PLEASE UNDERSTAND THAT IT IS YOUR RESPONSIBILITY TO CONFIRM CURRENT COVERAGE WITH YOUR INSURANCE AND NOTIFY THE FRONT DESK OF ANY CHANGES 48HRS BEFORE YOUR APPOINTMENT TIME.

_____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I would like to give the following persons access to personal health information. (ex: spouse or family)

Name: _____ Relation: _____

Name: _____ Relation: _____

Signature (patient/parent/guardian):_____Date: _____