FINANCIAL POLICY

All fees are due at the time of treatment. For treatment requiring lab work (Crowns, Bridges, Dentures, Bite Splints, Implants, etc.) one-half of the fee is due at the first appointment with the balance due at delivery.

Our business associates will be happy to assist you with these payment options:

- Cash or Personal Check*
- Visa, Mastercard, Discover
- CareCredit

*Please note there is a $35.00 fee for returned checks

For our patients with DENTAL BENEFITS: Our staff will submit your insurance claims as a courtesy to you. The amount estimated and not covered by your insurance will be due the day of treatment. If payment is delayed over 30 days by your insurance company or pays less than estimated, it will become your responsibility for the balance. If your insurance company refuses to cover any treatment for any reason, your are responsible for the fees your insurance company excludes.

ONE BUSINESS DAY NOTICE REQUIRED TO RESCHEDULE OR CANCEL AN APPOINTMENT

We value and respect your time and hope you respect ours as well. When you make an appointment, we reserve that time exclusively for you. When you miss an appointment, it prevents us from serving another patient in need of our care. We make it a priority to call and confirm your appointment prior to the scheduled appointment time. If you need to change an appointment, **we require notice of at least one full business day.** If you miss an appointment or reschedule without allowing one full business day between the cancellation and the time of your appointment, there will be a **minimum charge of $50** for the missed appointment.

_____ _____

Signature of patient or responsible person **Date**

PLEASE TURN OVER FOR MORE INFORMATION →

PATIENT CONSENT TO DISCLOSE
PRIVACY ACKNOWLEDGE

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use, disclose and release my protected health information and/or x-rays 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)
- 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 Practice, which contains a more complete description of 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 healthcare 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.

_____

Printed Patient Name

_____ _____

Signature of patient or responsible person **Date**

**************************************FOR OFFICE USE ONLY**

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____
_____
_____
_____

_____ _____

Office Personnel (Signature) Date