OFFICE POLICY AND HIPAA AUTHORIZATION

PRIVACY PRACTICES

How we handle your health information is outlined in the handout you have received today. Your signature on this agreement allows us to 1)use and disclose information about you for treatment 2) seek payment from your dental benefits 3) and acknowledges that we have given you a Notice of Privacy Practices as well as showing your acceptance and agreement with our office policies .

FINANCIAL POLICY

In an effort to provide the highest level of professional care possible and keep dental fees down, we have established the following as our financial policy.

1. Payment is expected at the time of service. Payments can be made with cash, check, Visa, MasterCard, Discover or American Express.
2. A financial arrangement underwritten by Synchrony Bank or Lending Club can be made which offers the patient who qualifies the option of paying for dental treatment at no interest for six to twelve months or over an extended period at a reasonable interest rate.

INSURANCE

If your insurance policy offers dental benefits, we will be glad to file claims for you. The patient portions of fees are due at the time of service. Because we deal with multiple insurance companies who offer multiple plans and benefit options, it is not possible for us to know all the benefits your individual plan offers. It is very important that you read your benefit package and be aware of what your policy will or will not cover. Please remember the final responsibility for your account falls on you**, not your insurance company.** Our professional services are rendered to you and not the insurance company; therefore you are directly responsible for payment. If the insurance does not pay the claim in a timely manner, it is your responsibility to pay the balance immediately. **Should it become necessary to turn your account over to a collection agency, you will be liable for the collection fees as well as the amount owed on the account.**

APPOINTMENTS

An appointment is a special time that is reserved just for you. We strive to be on time for our patients and ask the same courtesy from you. If you are unable to keep an appointment we ask that you give us **24 hours notice**. We will reschedule your appointment as soon as possible. Should you fail to give a **24 hours** notice we reserve the right to charge a fee of **$ 50. 00**.

I have read and accept the office policies as they have been presented to me

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Patient's Signature **Date**

PLEASE READ CAREFULLY