FINANCIAL AGREEMENT and POLICY OF CARE

For patients without dental insurance, full payment for professional services is expected at the time of treatment.

If you are covered by insurance, any deductible and co-payment will be due on the day of your appointment. Insurance is a contract between YOU and your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. It is your responsibility to monitor your benefits and annual maximum. You agree to pay any portion of the charges not covered by insurance.

For your convenience, we offer the following payment options:

- Cash;
- Check;
- Credit (Visa, MasterCard, Discover);
- We also offer interest free or extended payment plans through **CareCredit®** dental financing (based on approved credit). Please ask if you would like more information.

Please give us at least 24 hours' notice if it is necessary to change and appointment. If an appointment is not kept, it is our policy to charge a fee of $50.00 for each half hour scheduled.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to 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 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 have received, read and understand your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I have also read and understand the Financial Agreement and Policy of Care and understand that this organization has the right to change any document from time to time. I am aware that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices, Financial Agreement and/or Policy of Care.

Signature_____ **Date**_____

If at any time you have a question or are unhappy about any treatment, fee or service, please tell us. We want our patients to be satisfied with the care and service we provide. "Treat others the same way you would want to be treated". For us, this golden rule will always remain the highest priority.