

Lake Orion Family Dentistry

Office Financial Guidelines

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Guidelines which we require you read and sign prior to any treatment.

**YOUR ESTIMATED PATIENT PORTION IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS
And CARE CREDIT**

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your insurance by filing the necessary forms so you can receive your full benefit. We do this as a courtesy to our patients because your insurance policy is between you and the insurance company. We make no guarantee of any estimated coverage due to changes in employment status or treatment at other dental or dental specialty offices. We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required copayments.

Minor Patients: The adult accompanying a minor and the parents (or guardian of the minors) are responsible for full payment. In a divorce situation, regardless of agreements between ex-spouses, the parent signing the health history form will ultimately be held responsible for the account and its payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre authorized to an approved Credit Plan, Credit Card, or payment by cash or check at time of service has been verified.

Missed Appointments: Unless canceled, at least 48 hours in advance, our policy is to charge for **each missed appointment** at the rate of \$50.00. Please help us serve you & our family of patients better by keeping your scheduled appointments.

Our expectations of you:

- 1) Payment of fees not covered by your insurance plan at time of treatment.
- 2) Please understand that the insurance policy belongs to **you** and we have no leverage to obtain payment from your insurance carrier.
- 3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *not* our fees or recommended treatment.
- 4) You will have to take responsibility for any fees your insurance has not covered after 90 days. The balance on your account will be charged to your credit card.

I hereby authorize Lake Orion Family Dentistry to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Lake Orion Family Dentistry; I understand I am responsible for any unpaid balances. I authorize Lake Orion Family Dentistry to charge my credit card with any unpaid balances 90 days after treatment has been rendered with my permission. I understand that treatment can not be completed until it is paid for (i.e. crowns will not be cemented, dentures will not be placed). I understand that if I do not have a credit card on file, I may be asked to pay in full before treatment is rendered. I understand I am responsible for all charges associated with this account and that interest charges of 1.5% per month will accrue on unpaid balances and a statement charge of \$5.00 will be added to subsequent statements. A \$25.00 fee will be assessed for all returned checks.

Responsible Party Signature

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

- 1. A defense to a claim challenging our professional competence;
- 2. A review entity's functions;
- 3. A claim for payment of fee's;
- 4. A third party payers examination of our records;
- 5. A court order as a part of a criminal investigation;
- 6. An identification of a dead body;
- 7. A licensure investigation; or
- 8. A child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient/Guardian Signature

PATIENT CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient/Guardian Signature

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Office Use Only

____ Patient Refused to Sign

____ The following circumstances prohibited the patient from signing the Acknowledgment:

____ An emergency situation prevented the patient from signing the Acknowledgment.

Office Personnel (signature)

Office Personnel (print name)

Date_____