Patient Agreement and Authorization

I. Treatment Plan Estimates

Advanced Dental Care Prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to Advanced Dental Care when the estimate is made. As your treatment progresses your dentist may determine in a consultation with you that different or additional treatment is necessary, and your financial responsibility may change.

If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. In all cases, you are responsible for amounts not covered by your insurance unless prohibited by law or contractual agreement. In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

II. Predetermination of Insurance Benefits

If you have insurance benefits, you may have the option to seek a Predetermination of Benefits before you proceed with any treatment. Predetermination of Benefits is a process whereby your insurance company or plan administration tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures, and the amount you may be required to pay. Requesting a Predetermination of Insurance Benefits is like submitting a claim before the dental procedure or service has taken place. Because the Predetermination comes directly from your insurer or plan administrator, the risk of error as to your coverage is reduced. If your treatment includes extensive or complex services, such as bridges, crowns, dentures or periodontal work, a Predetermination may be particularly helpful to allow you to appropriately budget for the services or discuss any potential alternative treatment that may be available, if necessary. The Predetermination of Benefits process give you useful information about what services may be covered. However, your insurer will inform you that a Predetermination of Benefits is not a guarantee of coverage. A Predetermination sets forth your expected benefits based on the information available to the insurer at the time the Predetermination is prepared. The predetermination may not consider, for example, a prior claim submitted by another dentists for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services are actually provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by your dentist. The time it takes to receive a Predetermination from your insurance company or plan administrator can vary from as few as two weeks to as many as eight weeks. The decision to seek a Predetermination of Benefits or to proceed with treatment immediately is your on unless your plan requires otherwise. **Please inform the Office Manager if you would like to request a Predetermination or Benefits from your insurer.**

III. Payment Policy

In all cases, Advanced Dental Care patients agree to the following payment policies:

- Payment in full of the estimated patient portion of the fees is due at the time services are provided.
- For comprehensive treatment plans requiring multiple office visits, Advanced Dental Care requires a minimum deposit of 60% of the total estimated patient portion of the fees at the time of scheduling the appointment.
- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law, or unless Advanced Dental Care has a contractual agreement with my plan prohibiting all or a portion of such charges.

As set for below in the Refund Policy, any portion of your deposit for services not rendered will be refunded if you choose not to proceed with your full comprehensive treatment plan.

IV. Refund Policy

You may discontinue treatment and ask for a refund from Advanced Dental Care at any time. Advanced Dental Car will refund any amount paid for treatment planned that you did not receive, except when Advanced Dental Care's Policy for Interrupted Denture Services, set forth below, applies. Refunds will be mailed or transmitted within fifteen (15) business days of our receipt of your request. If you have paid for services not yet provided and fail to cancel your appointment win the 24hour cancellation timeframe a 20% fee of the deposit will be assessed. If you do not return to our offices for six (6) months, Advanced Dental Care will send you a written notice offering a prompt refund of your balances. Refunds will be made in the same manner as the original payment, except cash payments will be refunded by check. All Requests for refunds should be directed to the Office Manager.

V. Patients with Insurance

Advanced Dental Care's Payment Policy, stated above, applies to all patients, including those with insurance, subject to the following:

A) In Network – If Advanced Dental care is a participating provider in your plan network, your insurer may impose on Advanced Dental Care requirements that can impact your obligation to pay. For example, Advanced Dental Care may be required to receive approved from you in advance of treatment for non-covered services or may charge you only your co-payment at the time covered services are provided. In all cases, Advanced Dental Care will bill you pursuant to the terms of its agreement with your insurer.

B) Out of Network – Even if we are not a participating or in-network provider with your insurance plan, we may still work with your plan on an out-of-network basis if you assign benefits to be paid to Advanced Dental Care will reduce your payment or deposit by your estimated insurance benefit, but you must assign the benefits directly to Advanced Dental Care. If the insurance plan will not pay benefits directly to Advanced Dental Care, you will bear the financial responsibility for your treatment plan according to our payment policy.

C) Insurance Discounts – Insurance companies often negotiate discounts with Advanced Dental Care for services provided to their plan members. Advanced Dental Care will charge additional services at the discount rate even after the insurance benefit has been exhausted when the agreement between your insurer and Advanced Dental Care so requires.

VI. Interrupted Denture Service Changes

Patients requiring dentures may cancel their dentures at any time during the fabrication process prior to the completion of your dentures. If you choose to cancel prior to completion, you will be charged $100 per visit for each step in the fabrication process, not to exceed $300, depending on how many steps have been completed. Once your denture is fabricated, you are responsible for its full fee.

VII. Accepted Forms of Payment

Advanced Dental Care accepts cash, personal checks, Visa, MasterCard, American Express, and Discover, assigned insurance benefits, and approved third-party financing.

VIII. Third-Party Financing

Advanced Dental care offers treatment financing through third-party lenders, such as CareCredit®. Advanced Dental Care pays these companies fees on a sliding scale for making loans available to its patients and for servicing these loans. As the aggregate amount of care financed through these lenders increases, the fees they charge Advanced Dental Care decrease. This sliding scale pricing arrangement does not affect your loan amount or the cost of your treatment.

1. Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read Advanced Dental Care's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____Date_____

(if patient is a minor or disabled, the Parent, Guardian, or Attorney-in-Fact must sign above and complete the Responsible Party Section below)

2. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients with insurance and those who expect to obtain insurance.)

By signing below, I acknowledge that I have read, understand and agree to the terms of the attached Advanced Dental Care Financial Arrangement Policies. I acknowledge that I have been informed of the treatment plan and estimated fees. I agree to be responsible for all charges for dental serves not paid by my dental insurance plan, unless prohibited by law, or unless Advanced Dental Care has a contractual agreement with my plan prohibiting all or a portion of such charges.

Signature_____Date_____

(if patient is a minor or disabled, the Parent, Guardian, or Attorney-in-Fact must sign above and complete the Responsible Party Section below)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by ALL new patients with insurance and those who expect to obtain insurance.)

To the extent permitted by law, I consent to Advanced Dental Care's use and disclosure of my protected health information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment of the dental benefits otherwise payable to me directly to Advanced Dental Care.

Signature_____Date_____

(if patient is a minor or disabled, the Parent, Guardian, or Attorney-in-Fact must sign above and complete the Responsible Party Section below)

Responsibility Party (if Patient is under 18 or disabled)

Circle one: Dr/Mr/Mrs/Ms/Miss

First:_____Middle:_____Last:_____Jr/Sr:_____

Street:_____City:_____State:_____Zip:_____

Home Phone:_(_____)_____Work Phone:_(____)_____Cell Phone:_(____)_____

Patient SSN:_____-_____-_____Patient Date of Birth:_____/_____/_____Sex (circle) M F

Signature:_____ Date:_____