**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Statement of Financial Policy**

Patient Name

Thank you for choosing Wilburton Family Dentistry as your dental provider. We are committed to providing the best dental care possible.

Your clear understanding of our financial policy is important to our relationship and payment of your bill is considered a part of your treatment. The following statement explains our financial policy and we ask you to read, sign and return it to us prior to your treatment.

**Please ask any questions you have about our fees, financial policy or your financial responsibility before seeing doctor.**

**\_\_\_\_\_\_\_ Payment for services**

Initial

1. *Payment in full is due at the same time of service;* this includes, but is not limited to, the following:
2. All appliances co-pays, co-insurance and outstanding deductible amounts,
3. Services covered by out-of-network, secondary and Medicare supplemental insurance companies
4. Services not covered by insurance or third party payers
5. To obtain balances owed by you or your family members must be paid before any additional services are rendered.
6. For minors, the adult accompanying the minor is responsible for full payment. If a minor is accompanied by anyone other than the parent or legal guardian, a written release is required.
7. If a refund is due, patients will be contacted to see if a check is to be issued or if they would like the money left on their account for use of future dental treatment.

\_\_\_\_\_\_ **Regarding Insurance**

Initial

1. Your insurance is filed as a courtesy to you. All services not paid within 60 days by your insurance will become your responsibility.
2. Insurance is a contract between you and your insurance company. We are not a party to your contract; however, we may have a contractual fee schedule agreement with the insurance company.
3. All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor. If this information is not correct in our patient records it may result in non-payment by your insurance carrier and the balance will transfer to you.
4. If you do not provide a current insurance card, you will be responsible for all charges at the time of service and an insurance claim WILL NOT be filed on your behalf.
5. We will not become involved in disputes with your insurance company regarding deductibles, non-covered expenses, co-insurance or “reasonable and customary” charges other than to supply factual information as necessary.
6. The patient responsibility portion of your bill cannot be finalized until a claim has been filed with your insurance company and an explanation of benefits has been received from your insurance company. We do our best to “estimate” what the insurance will pay, anything not paid by insurance will be the patients responsibility.

\_\_\_\_\_\_ **Missed Appointments/Records**

**Intial**

1. Please help us to serve you better by keeping scheduled appointments. Unless cancelled 24 hours in advance, our policy is to charge $50.00 for a missed appointment. Future appointments cannot be scheduled until this fee is paid; this fee is not covered by insurance so it will be your personal responsibility.
2. Arriving more than 15 minutes late for an appointment will require your appointment to be rescheduled.
3. All diagnostic aids, such as radiographs (x-rays), are property of Wilburton Family Dentistry and may not be taken by the patient. Dental records can be copied upon request if patient desires treatment at another office or be referred to another office for specialized treatment.
4. Request for release of dental records require the patient or patient’s guardian to complete an authorized form for release of protected dental information- we can provide you with a copy of this form. A release is not considered RECEIVED until a signed release form is in our possession.

\_\_\_\_\_\_ **Past Due Accounts and Returned Checks**

Initial

1. Overdue accounts will be referred to a collection agency. Legal fees and collection fees that we pay to secure past due balances will be added to your account.
2. For checks returned to us as unpaid by your bank, we will charge a $25.00 fee.

**I have read and understand the above Statement of Financial Policy**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Name Signature Date

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information 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 and Privacy Practice*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the term 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 to 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 restricted. However, if you do agree, you are then bound to comply with this restriction. I understand I may revoke this consent, in writing, at any time. Any use or disclosure that occurred prior to the date I revoke this is not affected.

**I have received HIPAA Notice of Privacy Practices Acknowledgement**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Signature/Guardian Date