## Office Policies

## Welcome to our office! Please review the following office policies.

**Insurance**

As a courtesy to our patients, our office is happy to help file your insurance claims so that you can receive the best of your benefits. Insurance plans vary from company to company. Insurance benefits are determined by the plan your employer has chosen for your company and can vary within the same insurance carrier. It is a contract between you, your employer and the insurance company. **Insurance is not a guarantee of payment and may not cover all the costs involved in treatment.** It is up to you to know what your insurance covers and what it will do for you. Your insurance plan will only pay what it allows for each procedure, regardless of the actual fee. Any outstanding balance after insurance has paid is the patient's responsibility. We do our very best to determine what your financial responsibility will be at the time of treatment, however, this is just an **estimate** and can change after the claim is processed. Deductibles and co-payments are typically required for most plans and payment of these fees are regulated by state law. Therefore, they must be collected at the time of treatment.

**Financial**

Before treatment is performed, we will discuss treatment that is to be completed and the estimated cost to you. Sometimes this treatment can change slightly after it is started due to cavities being larger than initially believed. We accept cash, check, Visa, Mastercard and Discover as forms of payment. We also offer Care Credit, which is a financing option available.

For patients without insurance, payment is due at the time services are rendered. Patients with insurance are expected to pay the estimated co-pay and deductible at the time of service.

For parents of minor children, the parent who brings the minor in for treatment must be present during treatment and is responsible for all fees incurred.

For balances over 30 days there is a $5.00 billing charge, and for balances over 90 days a finance charge of $25.00 will be charged.

Checks returned for insufficient funds or closed accounts will be charged a $25.00 fee. If a check is returned, cash or credit card will be the only accepted forms of payment going forward. If a collection agency becomes involved for any unpaid balance on your account, all collections costs and legal fees for both parties are the responsibility of the account holder.

**Appointments**

Appointment times are reserved especially for you. If you are unable to make an appointed time, 24 hours notice is required so that we may offer your time to another patient. If 24 hours notice is not given, your appointment may be appointed a few weeks out if rescheduled. If this happens more than three times, you may not be able to schedule appointments ahead of time, and may have to call the day you have availability to check for open appointments. You may also be terminated from this practice in that case. If you are late for your appointment, I may be rescheduled depending on the type of procedure.

**Consent**

I have read and understand the above information. (For patients with insurance, your signature below authorizes assignment of insurance benefits to the doctor).

Signature of Patient/Parent/Guardian _____ Date_____

FREIBERG
FAMILY DENTISTRY

## HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor the agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing you understand that:

- Protected health information may be disclosed or used for the treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information, but the practice does not have to agree with those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosure will cease.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home/Cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If Yes, please list the name and relation of family member below allowed to discuss you condition:

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This consent was signed by:_____

Signature:_____ Date:_____

Witness:_____ Date:_____