OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for choosing Dr. B. Dentistry to service your dental needs and concerns. The following describes our office policies and financial agreement. We ask that you please read, agree to, and sign this document so that we have your permission to provide the highest standards in quality dental care.

_____ **SOCIAL SECURITY NUMBER DISCLOSURE.** We understand the growing need to protect your identity from theft. Please rest assured knowing that your information is safe with us as we are in compliance with the Health Insurance Portability and Accountability Act (HIPPA) and Payment Card Industry (PCI). Our desire for social security numbers helps us to serve our patients better. We use your social security number to verify your account information and medical records thereby reducing the possibility of duplicate accounts or charts. It is also used to verify insurance benefits and submit claims on your behalf. If you are not interested in our extended services and are unwilling to provide a social security number, please be prepared to: pay in-full for all services provided at each visit, know that we are unable to provide estimates of insurance coverage, and notify a team member for further instructions.

_____ **PAYMENT OPTIONS.** Our office accepts payment in the form of cash, check, Visa, Mastercard, American Express, Discovery, Pay Pal, or Care Credit. For payments made in full on the day of service where claims will not be submitted to insurance, we offer a 5% discount when paying by cash or check. If you are interested in a zero-interest monthly payment plan, please contact any member of our administrative team to assist you in completing an application form for Care Credit, our financial partner. A fee of $40 will be charged on all returned checks as well as a reversal of any pre-pay discount. For those patients who have a history of less than five payments to the company, they will be expected to pay by only cash or credit/debit card for a period of three months before checks will be considered an acceptable form of payment once more. Please know that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

_____ **INSURANCE CONSIDERATIONS.** For patients paying with insurance, be prepared to show the insurance card and photo identification at the time of treatment. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Please know that we take pride in giving our patients honest, sincere recommendations based on their personal dental care needs, and not based on their insurance coverage. We submit dental insurance claims to insurance companies and strive to maximize insurance benefits as a courtesy to our patients. However, due to pending claims, privacy issues, and changes made by employers, we do not always know how much an insurance company has already paid or will pay. It is also important to understand that an insurance contract is between the insured and the insurance company, and that insurance was never designed to pay for all dental care. It is your responsibility to understand the type of insurance you have and the benefits selected by you and/or your employer. In order to reduce your immediate out-of-pocket expenses, the patient/guarantor authorizes Dr. B. Dentistry to accept upon receipt direct payment from the dental insurance company on behalf of the patient. Therefore, at the time of treatment the patient/guarantor is responsible for the estimated portion of payment that their dental insurance company does not cover. If, for some unforeseen reason, your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. It is the patient's responsibility to notify our administrative office of the order in which to process claims. If the patient does not disclose this order to us, we will use our professional judgment to decide for the patient. When a patient's dental insurance company requests monies in the case of an audit, Dr. B. Dentistry will submit the monies on behalf of the patient to the insurance company. It is then the patient's responsibility to reimburse Dr. B. Dentistry. For patient's/guarantor's billing to medical insurance, the patient/guarantor is responsible for notifying Dr. B. Dentistry on or before the date of service, and regardless of medical reimbursement, payment for services to Dr. B. Dentistry is expected in full on the date of service.

_____ **ACCOUNTS WITH CREDIT BALANCES AND DELINQUENT ACCOUNTS.** For any account that has a credit balance from duplicate payments, the patient can request a return of overpayment and expect a monetary check to be mailed to the most recent address on file within thirty days of the request. If the patient does not request a return of overpayment, any account that has a credit balance over $1.00 after 90 days will receive a monetary check by mail dependent upon the most recent address on file unless the patient requests that the credit balance be retained on the patient's account. To keep the responsible party informed of account activity, any account with monies due will receive a courtesy statement each month even if insurance payment is pending. After 80 days, a monthly

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finance charge of 1% will be applied to any account not paid in full, and the account will then be submitted to a collection agency.

_____ **COMMUNICATIONS.** By providing your e-mail address, we can communicate with each other regarding Patient's Protected Health Information (PHI). Forms of electronic communications (i.e. e-mail, facsimile, video chat, cell phone, texting) can never be absolutely guaranteed to be secure or confidential, and there is always a possibility that an unauthorized party may gain access. Therefore, you agree that we may not be able to the guarantee confidentiality with respect to the above means of communication. Any communications may become part of your medical record. Text and e-mail are not an appropriate means of communication for time-sensitive problems, in an emergency, or for disclosing sensitive information. In an emergency or a situation that could develop into an emergency, please call the office or 9-1-1 for further instructions or seek care at a walk-in clinic or emergency room. E-mail is checked during business hours; however, if you do not receive a response by the next business day, contact us by telephone or other means. We will not be liable for any loss, injury, or expense arising from a delay in responding to a patient, when that delay is caused by technical failure, which includes: 1) failures caused by an internet service provider or faulty telephone or cable data transmission, 2) power outages, 3) failure of electronic messaging software or e-mail provider, 4) failure of the business's computers or computer network, or 5) the patient fails to comply with the guidelines for use communications described in the agreement.

_____ **CANCELLATION POLICY.** If you are unable to keep an appointment, we kindly ask that you provide us with a minimum of two-business days notice. Our office does not accept cancellations or changes in appointments after-hours by voice-mail, so you must call during normal business hours. This courtesy allows another fellow-patient to utilize that appointment time for their needs and ultimately contributes to reducing the rising costs of health care. Any patient in active treatment who fails to comply with this policy two times in 12 months will be expected to pay a deposit to reserve their next appointment. The deposit amount will be 25% of the scheduled services (regardless of insurance coverage). Once the services are performed, the deposit will be credited towards the bill. Any leftover credit (in the case of insurance reimbursement) will be used towards the next appointment reservation or refunded if the patient so desires. If the patient again fails to comply with the policy, then the patient loses the deposit for that appointment and must place another deposit in order to reserve a second appointment. By adhering to this policy, our office can ensure greater appointment availability to our patients, thereby allowing us to take even better care of you when you need us most.

_____ **OFFICE HOURS**
Monday 8:00 am – 5:00 pm
Tuesday 8:00 am – 5:00 pm
Wednesday 8:00 am – 4:00 pm
Thursday 8:00 am – 5:00 pm
Friday 8:00 am – Noon

_____ **CLINIC HOURS**
Monday 7:00 am – 5:00 pm
Tuesday 7:30 am – 5:00 pm
Wednesday 7:00 am – 12:30 pm
Thursday 7:00 am – 5:00 pm
Friday 7:00 am – 12:30 pm

I have read, understand and agree to the above Office Policies and Financial Agreement. I have had an opportunity to ask questions regarding this policy to any administrative team member of Dr. B. Dentistry. I also understand that this agreement is subject to change, and that I can request a copy of the most recent version at any time.

Signature of Patient/Guarantor/Parent/Guardian Date

Name of Child (if applicable)

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