

# OFFICE POLICY

## PAYMENT

We accept cash, personal checks and credit cards (Visa/MasterCard/Debit). Please be aware that in the case of a returned check, a \$30 charge will be assessed in order to cover the cost that is incurred from our own bank. Payment in full is required at the time of services rendered. If you have insurance, it is our pleasure to file an insurance claim form on your behalf, however all deductibles and co-payments are due at the time of your visit. If your account is not paid within 120 days, you understand that the account will be turned over to a collection agency. The collection agency may charge an additional 35% in order to collect your balance due.

## INSURANCE AND YOUR RESPONSIBILITY

Though we will make every effort in filing claims for your insurance benefits, please understand that we cannot accept final responsibility for collection of your insurance benefits, as we are not a party to your insurance contract. It is our policy to verify benefits from your insurance company by phone or website. If you have any employer/insurance changes please notify us immediately. If you have secondary insurance, we will file this as a courtesy to you as well. If your insurance company has not made full payment within 60 days of treatment date, the balance of the account will be due from you. A claim form and receipt of payment will be available for your records.

## CANCELLATION POLICY

A **24 hour** advanced notice is required in order to change a reserved appointment and to avoid a missed appointment fee. The fees are as follows:

PROPHY / EXAM: \$25.00                      RESTORATIVE WORK: \$25.00 per 1/2 hour scheduled  
Up to a maximum of \$100.00

**PLEASE TURN OFF YOUR CELL PHONES WHEN ENTERING TREATMENT ROOMS.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## CONSENT FOR USE/ DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ have received a copy of the office NOTICE of PRIVACY PRACTICES.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have a right to revoke this consent at any time by giving us written notice and submitting to our Office Administrator.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_