

Patient Name: _____

Parent or Legal Guardian Name: _____

OUR FINANCIAL POLICY

Regarding Payment & Insurance

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read, initial, and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS AND CREDIT CARDS. WE OFFER EXTENDED PAYMENT OPTIONS THROUGH CARE CREDIT PATIENT FINANCING.

We may accept assignment of insurance benefits; however, we do require your deductible and estimated percentage of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, an estimate will be given to you on the understanding that it is only a GUIDELINE from which to work until final payment is received from your insurance company and your **exact** share of the bill is known. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the insurance plan you have chosen. Please realize that professional services are rendered to a person and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We cannot render services on the assumption that the charges will be paid for by an insurance company. However, we will do all we can to estimate your portion of the treatment in advance. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Late Charges & Returned Checks

If your account is not paid in full within 30 days from the billing date your account will be considered delinquent and an \$8.00 rebilling fee may be assessed on your account monthly. When a check is dishonored or returned for any reason your account will be considered delinquent and a \$25 returned check fee will be assessed on your account and no checks will be accepted for any future visits.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I have read and I understand the Financial Policy. I agree to the above statements.

SIGNATURE (patient or legal guardian): _____ Date: _____

HIPAA CONSENT

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 (HIPAA). 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 of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms 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 on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

SIGNATURE (patient or legal guardian): _____ Date: _____

RELEASE OF INFORMATION CONSENT

I hereby give the office of Timberlake Dental permission to discuss any and all personal and/or financial information with the following:

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

Name: _____ Date of Birth: _____ Relationship: _____

SIGNATURE (patient or legal guardian): _____ Date: _____