Financial Policy

Patient Name_____

Thank you for choosing **GARDENS FAMILY DENTISTRY** as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to ANY treatment. Payment is due at the time services are provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. In the event it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do you have insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer (if applicable), and your insurance company.
- As a courtesy, to you we will help you process your in-network insurance claims. Please understand that we will provide an insurance ESTIMATE to you, however, it is NOT a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will of course, do all we can to make sure your estimate I as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the FULL amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to our office.
- We ask that you pay the deductible and co-payment, which is the ESTIMATED amount, not covered by your insurance company, by cash, check, credit card, or other patient financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in he claim being paid. Our office will not, however, enter into a dispute with your insurance company over ANY claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care to our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Gardens Family Dentistry. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of service are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provided including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient signature (Parent/Guardian if child) ***Date***

Patient Name_____

Acknowledgment of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*****You may refuse to sign this acknowledgement***** ***Date***_____

I, _____, have received a copy of the Notice of Privacy Practices.

Patient Name_____***Signature***_____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself, covered under the Privacy Act to people other than yourself.

I, _____, authorize to release information the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

Name (Printed) Relationship

_____ _____

Name (Printed) Relationship

_____ _____

Name (Printed) Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify) _____