16th Street Dental

Office Policies

Financial Policy Agreement

- Payment is expected at the time when services are provided. If you have insurance, the estimated patient portion of the fee is due at the time of service. Any other payment arrangement must be made in advance of services.
- We allow extra time for the insurance company to pay their estimated portion.
- If the insurance company has not fully paid a claim after a reasonable period of time, (usually 30 days) you will be required to pay that remaining portion.
- As a courtesy, we are happy to verify your benefits and bill your insurance. Information received is not a guarantee of benefits or payment from the insurance company, we use this information to estimate as closely as possible your insurance coverage.

- I understand that any costs incurred during treatment are my responsibility. I realize that insurance may help pay part of my treatment and that the estimates quoted to me are only *estimates*. I will be responsible for any fees unpaid by the insurance company. I understand that there may be monthly interest (1.5%) applied to the balance, and any additional costs of collection will be applied to the balance including; 40% fee to collections, plus any costs and interest charged by the agency to pay all attorney's fees.
- All procedures will be billed to patient's dental plan.

Cancellation Policy Agreement

- *I understand that if I fail to give **48 hours notice to cancel** a scheduled appointment, that I may be charged a fee up to the amount of the scheduled appointment procedure.*

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Initials

Notice of Privacy Practices Acknowledgement

- Under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA) I have certain rights to privacy regarding my protected health information. This information is used to conduct to your treatment, obtain payment from third party payers, and other various uses. I acknowledge that I have received your *Notice of Privacy Practices* containing a complete description of the uses of my health information and how I may restrict the use of this information.

Consent for Treatment

- I give consent for dental treatment by the doctor and staff.
- I understand that with each procedure there are particular risks and benefits. Possible risks for even routine treatment (such as fillings, crowns, root canals, and extractions) can be sensitive teeth, infection, paresthesia, traumatized pulp (nerve). Additional procedures may be required to treat any further complication.
- The practice of dentistry is not an exact science, and although we strive to give best care possible, guarantees cannot be made concerning the results of the treatment.
- I consent to the use of local anesthetics, antibiotics, nitrous oxide (laughing gas), and analgesics (pain medications) as needed to complete treatment.
- I understand that I may ask questions at any time regarding the risks and benefits and alternatives for any recommended treatment.

Signature of patient, parent or guardian	Date	Relationship to Patient
Signature of guarantor of payment/responsible party	Date	Relationship to Patient