Financial Information

Methods of Payment

Your portion is due on the date service is rendered.

1. Cash, check, or credit card (MasterCard, Visa, American Express, or Discover)
2. Dental Insurance (described below)
3. Application available for third party financing (Care Credit)

Dental Insurances

1. Our office will assist you in obtaining the maximum benefits specified in your contract. **However, your insurance is between you, your employer, and the insurance company**.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits. Our computer system will estimate your portion based on the information you have provided us. **We ask that your estimated co-payment and deductible be paid at the time of service.**
3. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.**

Related Information

1. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month or 18% annual. Returned checks will be assessed additional fees and will be turned over to the county attorney's office for collection if not paid in a timely manner.
2. In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for the collection of your bill.
3. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. **48 hour notice to change an appointment is required to avoid a $40 missed appointment charge.**
4. By signing this document, you acknowledge that you have read and understand the above information and that you are responsible (regardless of insurance) for any charges incurred from services rendered.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound by such restrictions.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Privacy Authorization

Staying within the reasonable guidelines of HIPAA, I give permission to Burchfiel Dental to discuss my dental care, related issues, and accounts with the following persons, in addition to myself. If none, please leave blank.

_____ _____

Name Relationship

_____ _____

Name Relationship

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and authorize the dental
Name of minor(s)

staff to perform necessary dental services for my child, including, but not limited to, X-rays and the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the time that treatment is rendered.

_____ _____

Signature of Patient/Parent/Legal Guardian Date