Financial Policy

Forms of Payment and Balances Due

In order to facilitate access to the very best dental care possible, you may choose from any of the following (*including any combination thereof*): **Cash, Debit, Visa, MasterCard, American Express, Money Order, and/or a *Previously Arranged* Payment Plan.**

Insurance

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. If your carrier is up to date, the claims will be transmitted electronically same day. If we receive an immediate response from your insurance company, we will know the total balance owing (if any) and collect payment at the completion of your appointment. If we do not receive an immediate response from your insurance company, at the conclusion of your appointment, we will collect a 30% prepayment (which is an estimate of what your portion would be after insurance has paid).

Some policies will not pay us directly. If this is the case, a cost estimate for the treatment done is given to you. Please understand that this is ***only an estimate***, and is based upon the information available to us. Your insurance claim will be sent by mail and we will then forward the remaining balance to you once we have received payment from the insurance company. ***It is your responsibility to inform us if there have been any changes to your policy(s) since your last visit.***

The range of benefits depends solely on what you or your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% - 80% range.

Some plans base the amount on a schedule of fees arbitrarily developed by insurance companies. For this reason you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means **80% of the fee arbitrarily determined by the insurance company** and not the actual fee charged by our office.

The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you and your employer, and not to our office. We request that you pay your estimated portion at each visit. If, for any reason, we have not received your insurance carrier's payment **30 days** after claim submission, the total remaining balance will be due and payable by you.

IT IS YOUR RESPONSIBILITY TO ENSURE ALL INFORMATION TO US AND YOUR INSURANCE COMPANY IS CORRECT. WE WILL BE UNABLE TO SUBMIT OR COLLECT ON YOUR BEHALF IF THE INFORMATION ON FILE WITH US IS INCORRECT.

I have read, understand and agree to all terms as stated above. I agree to pay all service charges that may be incurred should any balances remain unpaid after treatment.

X_____________________________________ __________________
(Signature of responsible party) (date)

I hereby authorize payment from my electronically submitted claim(s) be paid directly to Bear Creek Dental.

X_____________________________________ __________________
(Signature of subscriber) (date)

Personal Information Consent

We are committed to protecting the privacy of our patient's personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted by law.

We collect information from our patients such as names, home and work address, home, work and cell phone numbers, and email addresses (collectively referred to as "contact information"). Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- To process claims for payments or reimbursement from third-party health benefit providers and insurance companies
- To send reminders to patients concerning the need for further dental examination or treatment
- To send patient information and material about our dental practice
- Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical conditions, and dental treatments (collectively referred to as "medical information"). Patient's medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining a second opinion
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion
- To other health care professionals, such as physicians, if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access to patient information as part of the due diligence process in order to verify information important to the potential sale. If this occurs, we will take the steps necessary to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal and medical information as set out above.

________________ ________________________________ x______________________________

Date Print name Signature

Dependant children

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