Patient Name (Please Print)____

FINANCIAL POLICY AND INSURANCE BILLING

- **No Insurance Coverage/Insurance Co-Pay:** Charges are due and payable per terms of this agreement at the time services are rendered. For your convenience, our office accepts Cash, Check, MasterCard, Visa and Discover and Care Credit.
- **Dental Insurance coverage: Please be aware that even though you have dental insurance, your account is your responsibility, not that of your insurance company.**
    1. **Before or during your initial visit, we will call your insurance company to get benefit information. The representative will immediately read to us a disclaimer that they do not guarantee payment and that payment is based on a percentage of what they consider "Usual and Customary" fees.**
    2. **We urge you to be fully aware of the provisions of your policy, as we are not responsible for any errors, omissions or misinformation given to us by your insurance company.**
    3. **If your insurance carrier chooses to pay you, the patient, we will ask for full payment at time of service.**
    4. **Although we do our best to provide the most accurate information to you, it is possible that when payment is received from your insurance carrier there may be a remaining balance. Any balance remaining is due within 30 days.**
- **ALL PROFESSIONAL FEES ARE THE RESPONSIBILITY OF THE PATIENT OR PARENT/GUARDIAN. IF INSURANCE INFORMATION IS PROVIDED, WE WILL FILE YOUR CLAIM. DEDUCTIBLE AND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. FOR THOSE PATIENTS WHO DO NOT HAVE INSURANCE, FEES ARE DUE AT THE TIME OF SERVICE. A FINANCE CHARGE OF 1.5% COMPOUNDED MONTHLY (AN ANNUAL RATE OF 18%) WILL BE ADDED TO ALL ACOUNTS 30 DAYS PAST DUE.**

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that at my request, I will be provided with 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 from time to time and that I may contact this organization at any time to obtain a current copy.

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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Medical History Report

In Regards to the Medical History form that I filled out, to the best of my knowledge, the questions on that form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

By signing below, I am acknowledging Premier Prosthodontic's Financial Policy, HIPPA Privacy Act & accurateness of Medical History.

Signature of Patient, Parent, or Guardian ____Date____________