FINANCIAL POLICY

TO OUR VALUED PATIENTS

This policy was developed to clarify our office practices regarding insurance billing and payment for services. If you have any questions regarding a billing issue or a statement you have received, please let us know.

This office participates with many insurance carriers and for the convenience of our patients, bills the insurance carrier directly for services provided. To provide this service to our patients we require the following information: your insurance card(s) and/or ID#'s, current phone number and address. You have a contract with your insurer that may require that you pay a deductible, and/or co-payment. This is information that is available from your insurance carrier. Please verify this information prior to your appointment.

PLEASE INITIAL THE FOLLOWING

- To verify insurances coverages we request that you bring your current insurance card and/or ID#'s to every visit. If this information changes, or if there is a change in phone number or address, please alert the front desk. We request that you contact the office with any insurance changes prior to your office visit. It is the patient's responsibility to provide us with current billing information._____
- If you are unable to provide insurance cards and/or ID#'s, the service will be charged directly to you. Payment in full is due at the time of service._____
- Payment of any insurance co-pay is the responsibility of the patient. Payment of your co-pay is due at the time of service._____
- Outstanding balances are due prior to new services being rendered. We would be happy to arrange payment plans for large balances, however plans must be arranged prior to subsequent appointments being scheduled._____
- We accept cash, personal checks, debit & credit cards._____
- We will bill your primary & secondary insurance carrier(s) for services provided. You will receive a statement for any charges that are the patient's responsibility after the insurance has paid. If payment is not received from the insurance carrier after 45 days from the date of billing, the balance will be transferred to the patient._____
- Statements for outstanding balances are sent monthly and are due upon receipt._____
- All unpaid balances are reviewed for collection after 90 days._____
- We will establish monthly payment arrangements for qualified patients. If you wish to establish a payment arrangement, please contact our office manager or billing specialist._____

I have read, understand and agree to comply with this financial policy. I understand that I am financial responsible for the dental services I have received in this office. I hereby authorize the practice to release all information from my records necessary to secure payment of benefits for services provided. I authorize the use of this signature on all my insurance submissions.

_____Date:_____

Signature of the Patient or responsible party (indicate relationship to patient)

NOTICE OF OFFICE POLICIES

- **Late Show Policy:** Appointments are scheduled according to the procedure to be performed. Patients who are more than ten (10) minutes late will be asked to reschedule their appointment for another day, or asked to wait until the next available time.____
- **No Show/Late Cancellation Policy:** Our office operates on an appointment or schedule, except in a severe emergency. Therefore, it is critical to you and/or your child's continued care to keep every scheduled appointment. We do understand that unavoidable circumstances do arise, however, twenty-four (24) hour notice is asked for any cancellation. All patients are given a one-time No Show/Late Cancellation Grace, all other No Show/Late Cancellations will be assessed a **$25.00** fee. After three (3) No Show/Late Cancellations you and/or child will be asked to seek dental care elsewhere. We will be available to assist you in seeking alternative care if need be._____
- **Our office strives to see patients at their appointed time.** There are times, when an unforeseen problem or delay occurs during a procedure. Please have patience with our staff during these times; we will try, to the best of our ability, to see you or your child at the appointed time._____
- **Notice of Fees:** We reserve the right to access a **1.5%** finance fee charged on any account balance remaining after sixty (60) days from the initial date of treatment._____
- **Notice of Privacy Practices:** The Health Insurance Portability and Accountability Act **(HIPPA)** requires that, as of April 14, 2003, each patient be given the opportunity to read and/or keep a copy of this office's Privacy Practices. This document is available on line (www.ucsmiles.com) as well as at the front desk for your review.

- **Cell Phone Usage:** **(HIPPA)** requires that we protect the privacy of our patients. We are asking that you turn your cell phones off while in treatment areas. **Thank You.**

- **Minor/Child/Adult Consent:** I am the patient, parent, guardian or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child/patient named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

I, _____, have been offered or have received a copy of Matthew C. Christopher, DDS, PC Privacy Practice

_____ _____

Signature of Patient or Guardian **Date**

Additional Family Members: (Name and Date of Birth)

_____ _____

_____ _____

_____ _____