## Financial Policy

1. At the time of your appointment, any expected patient portion is due in full.
2. Visa, MasterCard, American Express, Discover, Care Credit, debit cards, cash and check are all accepted forms of payment.
3. There will be a $25 fee for all returned checks.
4. We will be glad to bill your insurance for you. **This is a courtesy and not a requirement.** We will bill up to two insurance companies only.
5. We are a participating provider with **most** insurance companies.
6. Patients having insurance will be required to pay any balance not expected from insurance dependent upon coverage at the time services are rendered.
7. Insurance companies use the term "usual and customary" when setting fee limitations on services. The term suggests, but does not necessarily reflect the average fees charged by doctors in our area. Please be aware that some insurance companies pay claims based on their fee schedules and not those of our office. You will be responsible for any difference due to usual and customary fees, deductibles or maximum benefits met.
8. If any balance due and owing is not paid within 30 days from the date of the invoice, patient will be charged an interest fee of 1.5% and may be sent to collections if no payment is received within 90 days.

**OUR OFFICE REQUIRES A MINIMUM OF 24 HOURS NOTICE FOR CANCELLATION ON ALL PROCEDURES. A CANCELLATION FEE WILL BE CHARGED TO THE PATIENT IF LESS THAN 24 HOURS NOTICE IS GIVEN. WE MAY ALSO DISMISS A PATIENT AFTER 3 MISSED APPOINTMENTS.**

## HIPAA Consent

I hereby acknowledge that I have been provided with a copy of this office's **NOTICE OF PRIVACY PRACTICES** and have therefor been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the notice.

## Records Release

I grant La Pine Dental permission to transfer my x-rays and medical treatment summary to licensed medical professionals for purposes of my dental/medical treatment now and in the future at my request or per La Pine Dental's referral (to specialists, other doctors, etc....)

**By signing below I acknowledge I have read, understand and accept the Financial, HIPPA, and Records Release policies as stated above.**

Patient's Printed Name: _____

Patient Signature: _____ Date: _____