# Office Guidelines

| ***Name of patient*** | ***Name of responsible party/relationship to patient*** |
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We realize that every person's financial situation is different. For this reason, we have worked diligently to provide a variety of payment options to help our patients receive the dental care needed to enjoy a healthy and confident smile.

## Payment Options

- Cash, check or debit card: We are pleased to offer a 5% courtesy discount for payment of the full fee at the time of service.
- Senior Discount (65+): 5% courtesy discount for payment in full at the time of service.
- Credit card: For your convenience, we accept payment by Visa, MasterCard and Discover.
- CitiHealth and Care Credit: These are outside financing companies that offer both interest-free and long-term financing programs. Additional information and applications are available from our office staff with an immediate response generally available. As a courtesy to our patients, application and processing fees are paid by the practice.
- Express Checkout Program: Because we value your time, we have created a program that allows you to leave a credit or debit card number on file with our finance department so that checkout is quick and easy. For routine preventive care visits, if your insurance check goes directly to you, we will run a payment for the total fee on the day of your visit. If your insurance payment comes to our office, we will apply the insurance check amount to your account and will then run the balance of the visit on your credit or debit card (not to exceed $50.00 per month). For our patients with treatment needs, we create specific financial arrangements using carefully researched insurance estimates. If a balance remains after the payment arrangement is completed, the balance will be run on the card on file (not to exceed $50.00 per month).

**Financial Responsibility**

- Your signature below indicates that you accept financial responsibility for the above-named patient. Unless prior arrangements are made, the person who accompanies a minor child is responsible for payment at the time of treatment. The practice is not obligated to pursue payment (including the receipt of insurance checks) with anyone other than the above financially responsible person.
- Unpaid balances that extend beyond thirty (30) days from first billing may accrue interest at a rate of 1.5% per month.
- There is a $30.00 charge for checks returned by the bank due to insufficient funds.
- A patient's personal credit history may be checked in order to establish an account with the practice.
- In the event of default, the account guarantor will be responsible for certified mailing fees, collection costs and/or related court fees.
- <u>Missed appointments</u>: When a patient misses an appointment and fails to contact our scheduling coordinator at least **TWO BUSINESS DAYS** prior to the scheduled appointment a reservation fee/refundable deposit may be required prior to future appointments being scheduled. In certain cases we will place you on a priority call list to call for same day/next day appointments that better fit the day/time you need. To assist you in contacting us, we provide a 24-hour answering service.
- A processing fee may be assessed if you request duplication of your records.

**Dental Insurance**

As a courtesy to our patients, we file insurance claims with all insurance companies. Any portion not covered by insurance is the responsibility of the responsible party. Unless prior arrangements are made, the patient will be expected to pay their portion at the time of service. Your insurance policy is a contract between you and your insurance company. We will not enter into a dispute with your insurance company over your claim. We will, however, provide information to support the necessity for treatment, which may assist you in recovering your benefits. Any insurance benefit that has not been paid becomes the patient's responsibility sixty (60) days after treatment has been rendered.

If you do not have dental insurance, the total fee is due at the time of treatment unless payment arrangements have been made in advance.

**Consent**

I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough decision. I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before treatment begins. My signature below indicates my acknowledgement of these guidelines. I authorize the office staff to check my credit history or to assist me in applying for outside financing. I also authorize the practice to accept assignment of benefits from those insurance companies that will pay the office directly.

Signature______________________________________________________ Date__________________________________

## HIPAA OMNIBUS RULE
## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
## AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ______________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Seidel and DeFilippo Dentistry Partnership. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER SPECIALISTS / PHYSICANS IN THE FUTURE.**

________________________________________ ________________________________________

Please ***print*** patient name | Patient ***signature*** (if age 18 or over)

________________________________________ ________________________________________

Legal Guardian/Parent ***Signature*** | Description of Authority (Ex. - Mother/Father/etc.)

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other ________________________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents and any caretakers who can have access to this patient's records)

Name: ______________________________ Relationship: ___________________________

Name: ______________________________ Relationship: ___________________________

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION** VIA:

Cell Phone Confirmation: ______________________ Text Message to my Cell Phone: _________________
Home Phone Confirmation: _____________________ Email Confirmation: __________________________
Work Phone Confirmation: _____________________

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

Cell Phone Message: ________________________ Text Message to my Cell Phone: _________________
Home Phone Message: _______________________ Email: _____________________________________
Work Phone Message: _______________________

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of Gettysburg Dental Associates/Just Kids via:

Phone Message: ___________________________ Email address: ___________________________
Text Message: ____________________________ ☐ **None of the Above (opt out)**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third part remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____ I could not communicate with this patient ____
The patient refused to sign ____ Other (please describe) ________________________________________
________________________________________________________________

________________________________________
Signature of Privacy Officer