ORCHARD CROSSING FAMILY DENTISTRY FINANCIAL & PRIVACY AGREEMENT

Thank you for choosing our office as your Dental Healthcare provider. This agreement is to inform you of your obligation to our practice. This agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. Please understand that payment of your bill is considered part of your treatment.

INSURANCE

ALL CHARGES ARE YOUR RESPONSIBILITY regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Our practice is not a party to that agreement. We will fully cooperate with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

As a courtesy to you we will help you process and track all your insurance claims. We make every effort to accurately estimate your benefits prior to your appointment. However, most insurance companies do not give an accurate estimate until the actual claim is received and processed. The benefits we are given by your insurance company are an **ESTIMATE only** and **NOT** a guarantee of payment.

On the day of your appointment, you will be asked to pay the portion that we estimate the insurance company will not pay based on your coverage. We then file the claim and the insurance portion will be paid directly to our office. If the insurance check is paid directly to you, then you will be asked to pay the entire portion at the time of treatment. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement**. If payment from your insurance company is not received within 60 days from date of service or if your claim is denied, you will be expected to pay the balance in full at that time.** In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

PAYMENT OPTIONS

Our goal is to help remove financial barriers so our patients can receive the dental care they need and desire. We accept cash, checks, debit and most major credit cards. We also offer interest free financing through our In-office financing or through CareCredit for patients who qualify. **Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided.** Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. Returned checks and balances older than 60 days will be subject to NSF fees and finance charges at the rate of 1.5% per month (18% annually).

The undersigned also agree(s) to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

DENTAL RECORD POLICY

Your personal medical record provides a history of treatment, medication, and diagnostic information that enables your dental healthcare team to make comprehensive dental evaluations. We consider your record to be confidential.

Therefore, information will not be released without your written consent, unless required by law. Copies of any x-rays or dental records will be released to you or transferred to another dentist upon written request. **There will be a $35 charge for this service for each patient's x-ray and/or record transferred.**

APPOINTMENT POLICY

To make sure that every patient gets our individual attention, we set aside a dedicated time for each appointment. If you are unable to keep your scheduled appointment, please notify us 24 hours in advance so we can accommodate other patients. ***Our No-show/Cancellation policy is as follow: our practice will charge you (not your insurance) $75 for appointments that you do not keep and for appointments that you do not cancel with 24 hours notice.*** We schedule our patients per appointment because you deserve exclusive, personalized time with the doctor and staff. Our office strives to see every patient at their appointment time. In order for us to do that, it is important that you arrive on time. If you are late by 15 minutes or more, your appointment may take longer than scheduled or may be rescheduled for a different date and time.

Phone cancellations will only be accepted during business hours and NOT when the office is CLOSED. Messages left on voicemail for appointment changes or cancellations will not be accepted, you must speak to a team member during our regular office hours.

OUR NOTICE OF PRIVACY PRACTICE & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

By, Law we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office and post it on our website.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Orchard Crossing Family Dentistry, 2090 Orchard Road, Montgomery, IL 60538. Telephone No. 630-859-3550.

Right to Revoke: You have the right to revoke this consent of our use and disclosure of your protected health information at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke your consent.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO ORCHARD CROSSING FAMILY DENTISTRY. I ACKNOWLEDGE THAT I RECEIVED A COPY OF ORCHARD CROSSING FAMILY DENTISTRY'S NOTICE OF PRIVACY AND POLICIES.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party **Date**