Dr. Stanley Altizer
COSMETIC AND FAMILY DENTISTRY

Name:_____

Date: _____

# Financial/Insurance/Attendance Policy

Our practice is committed to providing excellent dental care and the best personal service for all our patients. Our goal is to make it financially possible for you to obtain the dentistry necessary to achieve and maintain excellent oral health. In the combined interest of professional dental practice and good business service, we believe it is best that we establish a clear financial policy for every patient.

Please read, sign, and return the following:

## PAYMENT:

**Payment for service is due at the time services are provided for anyone that does not have insurance. For those patients with insurance, we will estimate the patient portion of the bill and payment is due at the time services are provided. If we can not verify your insurance, services must be paid in full at the time they are performed. We accept cash, check, bank debit, Visa, MasterCard, Discover, and Care Credit.**

**PAST DUE ACCOUNTS: If a balance remains on your account after 60 days, interest will accrue to your unpaid balance at the rate of 1.5% monthly (18% annually). Our office cannot carry balances in excess of 90 days. An account over 90 days past due may be referred for collection purposes and all costs and fees associated with collections will be charged. A service charge of $35.00 will be assessed in the event of a returned check.** The parent or guardian of a minor is responsible for full payment of any rendered services, including those of separated and divorced parents (the parent who brings the child to the office).

## INSURANCE:

We gladly submit insurance claims as a patient courtesy. If you have insurance, please be prepared to pay **your share in full the day service is rendered** and provide our office with **accurate** insurance billing information. Once your claim is filed, we allow your insurance provider 30 days to complete payment. After 30 days, you are responsible for payment in full of any balance.

We strive to be accurate about the amount of your coverage, but with thousands of different plans available, we cannot guarantee your coverage in our estimate. The benefit received is determined by the terms of your dental plan purchased by your employer, and by how much remains in the dental benefit for the year. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. At your request, we will be happy to submit a pre-authorization for recommended treatment. Patients are responsible for paying all charges not covered by their insurance plans, including all fees considered above their particular insurance policy's arbitrary "usual and customary" fee schedule.

**OVER**

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**Missed or Cancelled Appointments:** Once an appointment has been made, please remember that this time has been reserved exclusively for you. We reserve the right to charge a fee for missed appointments or appointments cancelled with less than 48 hours notice. If an appointment is missed or cancelled without 48 hours notice three times within a 12 month period, a deposit will be required to schedule any future appointments.

As a courtesy and when time allows, we will attempt to confirm your appointment by postcard, text message, email, or phone. However, this is only a courtesy. Ultimately, it is your responsibility to keep your scheduled appointments.

We appreciate your understanding and will address any questions about financing options, insurance, and your account. We are here to make this process as easy as possible.

***I/we understand and agree to this Financial/Insurance/Attendance Policy***

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**Signature of patient/responsible party** **Relationship to the patient** **Date**

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1995 (HIPAA), 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 have the right to read the *Notice of Privacy Practices* before deciding whether to sign this *Consent*.

This office reserves the right to change the privacy practices as described in the *Notice of Privacy Practices.* If it is changed, a revised *Notice of Privacy Practices* will be issued.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**Patient Name: _____**

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**Signature of patient/responsible party** **Relationship to the patient** **Date**