



## Financial Policy

***FULL PAYMENT IS DUE AT THE TIME OF SERVICE.***

**We accept cash, checks, and credit cards. We offer an extended payment plan with prior credit approval. There will be a \$30.00 charge for all checks returned for non-payment. Regardless of insurance, any balance left over 90 days, will incur interest and all fees associated with collecting your balance.**

### **Our Policy on Insurance Acceptance:**

We will file your insurance as a courtesy, however if your insurance does not pay the claim within 60 days of the date of service, you are responsible for payment in full of the balance due. All co-pays and deductibles are due prior to treatment. It is your responsibility to give us correct insurance information. In the event we are non-network providers for your insurance plan, we require that you provide a valid credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be billed to your credit card. Please be aware that some of the services provided to you may not be covered and /or not considered reasonable and necessary under the provisions of your dental plan. ***You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.*** The parent and/or guardian accompanying a **minor patient** are responsible for full payment.

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Expiration Date

### **\*Missed Appointments\***

**Unless rescheduled or canceled, at least two business days in advance, our policy is to charge for missed appointments at the rate of a normal office visit.** Please help us to serve you better by keeping scheduled appointments.

## Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize Jones Bridge Dental Care to use and disclose my protected health information to carry out the following:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
2. Obtaining payment from third party payers (e.g. insurance company)
3. The day-to-day healthcare operations of Jones Bridge Dental Care.

I have also been informed of, and given the right to review and secure a copy of **The Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. However, if the management at Jones Bridge Dental Care does not agree to these requested restrictions, then Jones Bridge Dental Care is not bound to comply with said restrictions. Thank you for understanding our Financial Policy and Patient Consent. Please let us know if you have questions or concerns.

I understand it is my responsibility to inform this office of any changes in my medical status. I have read the Financial Policy and Patient Consent. I understand and agree to this policy.

X \_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date