# Great Lakes Dental Care P.C.

## No-Show/Cancellation Policy:

Our office will charge a fee of $100.00 to your account for all "no-shows" or cancellations in which the patient does not give our office at least 24 hours notice. The office requests that if you are unable to make your scheduled appointment, you call to re-schedule your appointment. If it is after or before regular business hours please leave a message and we will return your call.

_____
Initials

## Financial Agreement:

All estimated co-pays are to be paid at the time of service. If you are unable to fulfill your financial responsibility we do reserve the right not to render services at the scheduled appointment. Our office accepts cash, personal checks, money orders, MasterCard and Visa. Outside financing is available thru Care Credit upon request and approval. Our office does not accept payment plans and you may be subject to a billing fee if a statement is sent. Returned checks will be subject to a $30.00 returned check fee.

_____
Initials

## Assignment of Benefits:

Our office will accept assignment of benefits from your insurance company with the provisions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- We will bill your insurance company as a courtesy with your consent as signed below.
- We require you pay the estimated portion not covered by your insurance company at the time we provide service to you.
- The portion that we estimate, is only an estimate which could result in an additional amount due after benefits have been paid to our office.
- Insurance is ordinarily received within 30-45 days from the time of billing. If your insurance company has not made payment to our office within 45 days, you will be responsible for the entire balance at that time. At that point you will be responsible for seeking reimbursement from your insurance company at that time.
- We do not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- We will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation if your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and accept the terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to Great Lakes Dental Care P.C.

_____
Initials

## HIPAA/ Patient Privacy Act:

The Health Insurance Portability and Accountability Act requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are offering to give you a copy of our Notice of Privacy Practices. This policy contains information that HIPAA requires us to disclose regarding our privacy practices.

We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information except for our disclosures in connection with: defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

It may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide material to a laboratory or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

_____ _____
Patient Signature (Parent/Guardian if under 18) Date

Please list any other person(s) that we may share your dental information with: