PAYMENT, TREATMENT, AND CANCELLATION POLICY

PAYMENT POLICY:

Keeping your mouth healthy means keeping you healthy! It is our goal to provide the best possible dental care for you and your family. We want to do everything we possibly can to make the best possible dental care both pain free and affordable. Please ask one of our administrative staff for information regarding payment options if you are interested. **Payment is due at time of service.**

As a courtesy for those with insurance, we will accept assignment of your insurance; though, your estimated portion is due at the time of service. The balance or any portion not paid by the insurance company within 60 days is your immediate responsibility. For the insurance plans that we are considered out of network with there are instances when your insurance company will pay the subscriber (patient) for the services provided to you in the office; If that happens it will be the responsibility of the patient to pay the total amount of the bill in full. We will file your insurance claim for you and your insurance company will pay you for the services rendered (unless previous arrangements are made).

IF YOU HAVE INSURANCE:

- You are responsible for providing current insurance information
- Estimated patient portions are due at the time of service
- Balance not paid by insurance within 60 days is your immediate responsibility

Please initial the following if you have insurance:

_____I understand that Dr. Gregory S. Fossum and staff are filling my insurance claim(s) on my behalf and that I am financially responsible for any amount that my insurance does not pay.

_____ I hereby authorize the release of information of my dental records to my insurance company.

_____ I hereby authorize direct reimbursement to Dr. Gregory S. Fossum

TREATMENT POLICY *(please initial the following)*

_____ I hereby authorize Dr. Gregory S. Fossum and his staff to perform the treatment necessary to maintain my dental health and hygiene.

CANCELLATION POLICY *(please initial the following)*

_____ I agree to provide 24 hour notice for any scheduling changes or cancellations to prevent fees from being assessed to my account.

I have read and understand the **PAYMENT, TREATMENT AND CANCELLATION POLICY**

_____

(Patient or Guarantor signature) Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluation and treatment.
- Your health information may be used for the purpose of obtaining payment.
- Your health information may be used as necessary to support the day to day activities and management of this practice.
- Your health information may be disclosed if mandated by law.
- Your health information may be disclosed to public health agencies as required by law.

OTHER USES AND DISCLOSURES REQUIRE YOUR SPECIFIC WRITTEN AUTHORIZATION

YOUR RIGHTS:

You have certain rights under the federal privacy standards. These include the following:

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your health information.
- The right to amend or submit corrections to your health information.
- The right to receive an accounting of how and whom your health information has been disclosed.
- The right to receive printed copy of this notice.

OUR DUTIES:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Please sign below in acknowledgement of these practices.

Signature: _____ Date: _____