

DENTAL CENTERS OF MISSOURI

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Financial Policy & Acknowledgement of Privacy Practices

Thank you for choosing us as your dental health provider. We are committed to your treatment being a positive and successful experience. The following is a statement of both our financial policy and our privacy policy.

Please note that full payment is due at the time of service.

We accept cash, checks, debit cards, Visa, MasterCard, Discover Card and Care Credit. We offer additional financing options that may be arranged for prior to the beginning of your dental treatment.

Regarding Insurance

We will accept assignment of insurance benefits and file dental insurance claims for you. We do require insurance co-pays and deductibles to be paid at the time of service. Any balance is your responsibility whether your insurance pays or not. Your insurance contract is a contract between you and your insurance company. We are not a part of that contract. We will obtain an estimate of insurance benefits from your insurance company prior to your appointment nevertheless it is just that an estimate. A final determination cannot be made until the work has been completed and a claim has been filed. We will be happy to file a pre-treatment estimate before beginning any work but please be advised it can take a minimum of four weeks to receive a response back from the insurance company. Any patient receiving treatment during hours that insurance cannot be verified is responsible for the full balance and we will provide you with the information that you need to submit your own claim.

Failed Appointments

We require that you notify our office 48 hours in advance to cancel your appointment. If cancellation occurs on the day of your scheduled appointment there will be a fee of \$25.00 to \$50.00 per scheduled treatment hour charged to you. After you fail three appointments we reserve the right to dismiss you as a patient.

Notice of Privacy Practice and Patient Acknowledgement

I have read and understand this practices Notice of Privacy written in plain language. The notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights, how I may exercises these rights and the practices legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and Financial Policy and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to this policy occur, this practice will provide me a revised Notice of Privacy Practices and Financial Policy upon request.

Please sign below stating that you are aware of and understand this agreement.

I have read the financial policy above. I understand and agree to this financial policy.
I have read and understand the Notice of Privacy Practice.
I have read and understand the Notice of Privacy Practice Patient Acknowledgement.

Signature _____

Date _____