Michael C. Regan, D.M.D.

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good oral health and we wish to spend our time and energy toward that end.

Estimated co-payments are due at time of service. We accept cash, checks, Visa, Mastercard, Discover and Debit cards. For patients who decline to give their social security number, we can only accept cash at time of service.

All accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with our Office Manager. On accounts which have established arrangements, the payment is due upon receipt of the monthly statement. Any balance outstanding more then 60 days will bear interest at 18% per annum or 1.5% per month (minimum $1.00).

Accounts which become delinquent may be subject to collection activity, and a $50.00 collection fee may be added to cover the cost of additional handling required. NSF checks will be subject to a $25.00 fee.

Office hours are by appointment and we do value your time. Appointment time is reserved for you alone. We will call to confirm your appointment but please make a note of any dental appointments we have scheduled for you. There will be a charge of $25.00 per 30 minutes of scheduled time for a no-show appointment or cancellation with less than 24 hours notice.

Insurances will be billed by the office as a courtesy. It is the responsibility of the patient to verify that the office has their correct insurance information and to inform the office if there are any changes with their insurance provider. Even though an insurance claim may be pending, a monthly statement will be sent to the patient for the outstanding balance of the account. The office cannot accept responsibility for collecting or resubmitting an insurance claim after 90 days or for negotiating a disputed claim. Remember, an insurance policy is a contract between the patient, the patient's employer, and the insurance carrier. Any questions or disputes about the insurance policy, for example what treatment is covered and by how much the treatment is covered, the patient will need to resolve with their insurance carrier. Ultimately, the PATIENT is responsible for the timely payment of their account.

It is not our intention to cause undue hardship, however we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read and accept the credit policy terms outlined above. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature_____Date_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Dr Michael C. Regan D.M.D.
6969 SE Lake Rd
Milwaukie, Oregon 97267
503-654-8283

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other