

# Preferred Dental

## Office Policy and Procedures

### **INSURANCE**

\*Preferred Dental is dedicated to helping you keep your smile healthy and beautiful for a lifetime. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. **As a courtesy**, we will complete and submit dental insurance forms to your insurance company to achieve the maximum reimbursement to which you are entitled and will strive to make this happen as quickly as possible.

**\*We can only estimate the amount your insurance company will pay toward each dental procedure and are not able to guarantee what your insurance company will pay. By signing this agreement, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company. These include any deductible amount, any amount that would be paid by co-insurance and insurance exclusions and/or limitations. We will file your insurance only under these terms.**

\*In some cases, your insurance company may have a maximum allowable charge for a procedure. This maximum allowable charge as determined by the insurance company, does not determine the fee you are charged for dental services and may be less than our quoted fee

\*In some cases, your insurance company may have a maximum yearly allowable. We will work with you to attempt to control your cost for the year to that amount, if requested.

**Please remember your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Whatever the insurance company does not pay or cover you are responsible for.**

Initials \_\_\_\_\_

### **PAYMENT**

Unless **previous** arrangements have been made, **payment is expected at time of service**. When multiple visits are required for treatment, your payment may be split over the number of visits required. If you have insurance, we will **estimate** the portion you are responsible for. However, if your insurance company does not pay in full, you are responsible for the difference. We accept cash, checks, Visa, MasterCard, Discover, AMEX and financing options are available.

Initials \_\_\_\_\_

### **RELEASE OF MEDICAL RECORDS**

\*You hereby authorize Preferred Dental to release copies of any and all information in your dental/medical records to other dental/medical providers or insurance carriers as a part of, or result of your treatment and/or to any other organization for the sole purpose of obtaining payment for dental/medical services provided to or for you or your dependent/s.

\*You release Preferred Dental, its employees and all other persons caring for you at Preferred Dental from any liability connected with the use of these records or the information in them by anyone outside of Preferred Dental

\*You understand that this release will remain valid until revoked in writing by you.

Initials \_\_\_\_\_

### **FINANCIAL RESPONSIBILITY**

\*By signing this agreement, you are indicating that you agree to the terms of this agreement, including being responsible for all legal fees, costs and an annual interest rate of 22% in the event that you breach this agreement. This agreement will be considered breached by you if Preferred Dental has not received payment in full within 30 days of your receipt of the final bill. In the event of breach of this agreement, all parties stipulate that Jackson County will be the county of jurisdiction to hear any dispute arising hereto.

Initials \_\_\_\_\_

### **2 DAY CANCELLATION POLICY**

For any scheduled appointment, we require 2 business days notice if you are unable to keep your appointment. **Failure to give us this notice will result in a \$50.00 charge per hour scheduled.** We are

aware that emergencies arise, and we are not insensitive to the issues. However, if you do not call us to let us know what is occurring, we reserve the right to impose this fee. We cannot provide our patients with the level of excellence expected of us if we do not have your cooperation with respect to keeping your appointment.

Initials \_\_\_\_\_

**AFTER HOUR EMERGENCY CARE**

Please be advised that there is a \$50.00 after hour emergency fee that will be charged if the doctor/staff come in to treat you after regular business hours. This \$50.00 fee is in addition to any fees for services rendered at time of visit. This \$50.00 after hour emergency fee and fee for treatment is expected at the time of service.

Initials \_\_\_\_\_

***You have read, or had read to you all of the above and understand all parts of this document.***

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Custodial Parent or Legal Guardian must sign if Patient is a minor under the age of 18 or legally incapacitated.

Witness Signature \_\_\_\_\_ Date: \_\_\_\_\_  
*A photocopy of this authorization and assignment shall be considered as valid as the original  
Rev 08/07*

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

“You may refuse to sign this acknowledgement”

I, \_\_\_\_\_, have received a copy of this  
(please print name)  
offices Notice of Privacy Practices. **(Copies are available at front desk)**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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**FOR OFFICE USE ONLY**

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Office Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date