

Office Policies:

Updated; September 2018

OPERATORIES: It is the policy of the office that **only the patient** is allowed in the operator: in the event that the parent/guardian is needed to accompany a child, it is up to the discretion of the provider if they will be allowed to stay in the operator for the length of the appointment. However if a parent/guardian wishes they will be permitted to walk a minor to the operator but then must return to the waiting room.

CANCELATIONS: Failure to show for appointments is extremely disruptive to our practice and can interfere with other patient's access to care, patients with three (3) or more "NO-SHOWS" may be dismissed from the practice. **There will be a charge for appointments missed or cancelled without a twenty-four (24) hour notice (\$25.00 for appointments 60 minutes or less, \$50.00 for appointments scheduled over 60 minutes in length). Saturday appointments need a forty-eight (48) hour cancelation notice and are a \$50.00 fee for appointments any length.** Visits may have to be rescheduled if you arrive later than your scheduled time.

PAYMENT: **PAYMENT IS EXPECTED AS SERVICES ARE RENDERED.** We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit. Any checks returned by your bank will be subject to a charge of twenty-five (\$25.00) dollars; this is subject to change without notice. **Accounts over 90 days past due may be referred to a collection agency and such accounts may be reported to a national credit agency. We may charge reasonable collection fees and attorney fees if we are forced to refer your past due account to a collection agency and/or an attorney.**

CO-PAYS: Accurate and complete information is required at your first visit. **If you have a co-pay, you are required to make the payment at the time of service. WE DO NOT BILL FOR CO-PAYS.** If your policy requires a deductible or co-insurance, we will estimate your portion. If you have a balance due, you will be billed accordingly. In the event of an overpayment, you will be refunded once all claims have been paid. We know co-pays and co-insurance have continued to rise. Please understand we cannot reduce or wave your co-pay or co-insurance. If you have a financial hardship or difficulty with your payments, please speak with a patient coordinator to discuss your options prior to your appointment.

INSURANCE: With the ever changing policies that insurance companies are now introducing we do our best to estimate accurately what your co-pays would be as well as payment from our insurance company. The agreement is between you and your insurance carrier, insurance carriers do not guarantee payment to our office, and any fees quoted to be paid are only an estimate. Unfortunately however in some cases we run into problems receiving payment. Baywest Family Dental will attempt to comply with the insurance company requests in any way possible. **If your insurance company denies your claim after our attempts you the patient are responsible to pay Baywest Family Dental in full, and any reimbursements that may come from your insurance company would go directly to you. OUR OFFICE WILL SUBMIT CLAIMS TO YOUR INSURANCE COMPANY AS A COURTESY SERVICE TO YOU. IT IS YOUR RESPONSIBILITY TO KNOW WHAT SERVICES YOUR INSURANCE PLAN COVERS;** we take NO responsibility to know what your insurance plan covers. Services that we render that are not covered by your insurance plan are your responsibility. We emphasize, as your health care providers, **that our relationship is with you, not your insurance company.**

INSURANCE CHANGES: If your insurance changes during the course of treatment, you must provide this information prior to being seen at your next appointment. Many insurance companies require authorization that will not be backdated for any reason. If there is a time lapse between the effective date of your new policy and informing the office of your new insurance you will be responsible for any claims that are denied for any reason including lack of referral and/or authorization.

NO INSURANCE: If you are not insured, payment will be expected at the time of service. Please speak with a patient coordinator if you have any questions prior to the start of your treatment.

MEDICAID: Our office accepts Medicaid until your 21st birthday. Once you have reached the age limit for our office you may ask for a referral to another office for future treatment.

MINOR PATIENTS: The adult consenting to treatment for the minor patient will be financially responsible for services rendered.

TRANSFERRING RECORDS: If, for any reason, you would like a copy of your entire record, you must request in writing, and pay a copying fee of \$1.00 per page. For your protection, please have proper ID with you if picking your records up in the office. Free Consultation and X-Ray coupon x-rays are non-transferable.

I have read the above Office Policies and fully understand what I have read. I agree to honor my financial commitment to this office as outlined. I can read English.

Signature of Patient/Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this acknowledgment

I, _____, have reviewed a copy of this office's notice of privacy practice (If you would like a copy, please request from front desk). Please list recipients who can receive treatment information regarding patient listed above.

1 _____

2 _____

3 _____

Print Patient's Name

Signature of Patient/Guardian

Date

*** Office Use Below * / * Office Use Below * / * Office Use Below ***

We attempted to obtain signed acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained due to the following reasons;

____ Individual refused to sign

____ An emergency situation prevented us from obtaining acknowledgment

____ Communication barriers prohibited obtaining acknowledgment

____ Other; Please specify: _____