OFFICE PAYMENT AND PRIVACY POLICY

UNINSURED PATIENTS

Will be expected to pay IN FULL at the time of service.

PATIENTS WITH INSURANCE:

DO NOT ASSUME THAT YOU HAVE COVERAGE.

To avoid unexpected charges, check with your **Medical** and **Dental** insurance carrier *prior* to surgery. You are responsible to know what your policy covers.
You are also responsible to get a referral if your insurance requires one.

Our office will attempt to contact your insurance carrier to verify coverage and your out of pocket costs. We will approximate your portion and you will be required to pay this portion at the time of service. (This includes any deductibles that have not been met, any amount above your insurance maximum allowable, any services not covered by your insurance, and your percent of co-insurance)

As a courtesy to the patient, we will file your insurance and hold the account for 30 days for the insurance to pay. If a remaining balance still occurs after your insurance pays, we will send you a statement. The balance is then due, *IN FULL, WITHIN 15 DAYS.*

The Patient is the responsible party for this account if 18 years or older. If under the age of 18, the parent who brings the patient in is responsible.

______________________________ ______________

Name of Patient (PLEASE PRINT) **Date**

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Signature of Responsible Party (AGE 18 OR OLDER) **Relationship to Patient**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

We are required by federal and state law to protect and maintain the privacy of your health and personal information. A copy of our privacy practices is available at any time. If you would like us to discuss your account with another party (ie: parent, spouse, children, etc.) for the purposes of treatment, payment activities, insurance and healthcare operations, please indicate so at the bottom of this page. You have the right to revoke this privilege to information at any time by submitting a written notice to our office. Please contact us with any questions regarding your privacy rights.

Patient Name: ______________________

Date of Birth: ______________

Name of Authorized Parties: ______________________

Relationship to Patient: ______________________

______________________________ ______________

Patient Signature **Date**