New Patient Agreement

Thank you for choosing us to provide you with dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. This financial agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask.

Dental Insurance: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- All charges that you were quoted as your portion will be your responsibility on the date of service.

Payment Policy

- We accept cash, checks, debit cards, Visa, MasterCard, Discover, and CareCredit.
- After your dental insurance has paid its portion, a statement will be sent to you if there is any remaining balance. Payment is expected within 30 days of the statement date to avoid 1.5% finance charge, unless prior financial arrangements have been made.
- Patients without insurance coverage will be provided a written statement of services to be provided. Payment is expected at the time that services are performed unless prior arrangements have been made.

Returned checks: A $25.00 charge applies when a check is returned by the bank

Finance charges and collection fees: Finance charges will be applied to all balances not paid within 30 days of the monthly billing date, unless prior arrangements were made in advance. A late charge of 1.5% on the balance will be assessed each month it is left unpaid. If your account should be turned over to collections you will be responsible for all collection fees.

We understand temporary financial problems may affect timely payment of your balance. In those cases we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

Broken or Missed Appointments: Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

A $75.00 broken appointment fee will be charged to your account if a 24 hour notice is not given.

Consent & Authorization: I authorize dental treatment and agree to pay all related professional fees promptly. I have read and understand this in its entirety, outlining office policies and financial procedures of Robert A. Smith D.D.S., Inc. I agree to abide by the policies outlined herein.

Acknowledgement of receipt of Dental Materials fact sheet: I attest that Dr. Smith has given me a copy of the dental materials fact sheet written by the CDA.

Patient Signature_____ **Date**_____

See reverse side

Rob A. Smith, D.D.S.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Patient Signature_____

See reverse side

Date_____