CORTEZ DENTAL CARE

HIPAA/FINANCIAL POLICY

Section I — Financial Policy

Patient Name:_____ Date of Birth: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

CANCELLATIONS: We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment. We require a two-business day advanced notice for any changes or cancellations of your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however, understand that illness and emergencies occur and we accommodate for those rare instances. **A fee will be charged to your account for not honoring this policy. For an appointment scheduled with our Hygienists, we will charge $30. For an appointment scheduled with our Dentists, we will charge $50.**

DENTAL INSURANCE: Dental insurance is a contract between your employer and the insurance company. We cannot influence how much of our fees your insurance will cover. Your benefits are determined by the policy your employer purchased. As a courtesy we would be happy to assist you in filling your insurance claim, but we are unable to accept responsibility for collecting your claim if there is a dispute.

PRETREATMENT AUTHORIZATION: Some insurance companies request an estimate of the work to be done and the fees to be charged before determining their benefits to you. We will file pretreatment claims with your insurance. It will be up to you to determine if you wish to proceed with treatment.

PAYMENT: Payment is due in full by cash, personal check, or charge card at each appointment as services are rendered. A charge of $20.00 will be assessed on checks returned for any reason. Checks placed for collections will have additional charges applied as allowed by Colorado Revised Statute 13-21-109. After two incidents of returned checks, we will no longer accept your personal checks. All accounts 30 days or over are past due and if not paid will be subject to collections. In the event you and/or your insurance company fails to pay and it is necessary to employ outside collection efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees, and collection agency fees.

Section II — Consent for Services (HIPAA)

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent.

Right to Revoke: You will have the right to revoke this consent an any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

Section III — Signature

Patient or guardian signature stating that they have read and understand Financial Policy and HIPAA. We reserve the right to change our practices at any time without notification.

Responsible Party's Signature_____ Date _____

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