Eastview Family Dental Financial Policy

We want our patients to be informed of our office financial policy. We realize that every person's financial situation is different. For this reason, we provide a variety of payment options to help you receive the dental care you may need with respect to your budget.

Then following is a summary of our financial policy:

Payment is due on the day of treatment

- Patients without dental insurance will receive a 5% accounting reduction for treatment paid the day of service. We accept cash, checks, all major credit cards, HSA cards and CareCredit.
  Your restorative treatment can be arranged so that you can pay as you go along through each phase of treatment. Orthodontic services and Invisalign would be excluded from that option.

- Patients with dental insurance will be responsible for an estimated portion due at the time of service As a courtesy to our patients, we find out benefit details so that we may provide an estimate and we will also submit your dental claims. These estimates are never a guarantee of payment, and the amount unpaid by insurance is the patient's responsibility.

Payment plans are available

- CareCredit can offer interest-free payment plans. Our staff can assist you with applying for these lines of credit. If approved, no payment is due at the time of service and you can get the care you need now, while paying over an extended period of time.
  These plans need to be in place prior to your treatment.

- Pre-payment can be made for future services

Balance Due

- If you receive a statement from us, the balance is due upon it's receipt. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Accounts with balances over 60 days are in arrears and will be charged interest at a rate of 1.5% per month.

Our goal is to assist you in receiving the optimal treatment needed to restore and maintain your dental health. If you have any questions or concerns about our financial policies, please do not hesitate to ask our office manager. Thank you!

I have read and understand the office financial policy:

Your Signature: ____*date*____/____/____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Effective September 1, 2013

I understand that, under the Health Insurance Portability Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and dental certifications.

In addition:

- You have the right to request that we do not disclose treatment for this service to a health/dental plan, if payment is made in full.
- You have a right to copies of your dental records.
- We are obligated to notify you in the event of a breach of unsecured protected health information.

I have received or have been given the opportunity to review and request a copy of a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If you have complaints about your privacy rights or how your health information has been used, you may file a complaint with us by contacting the Facility Privacy Officer in our office at 402-489-0787

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Patient Name (printed): ____

*(or) Name of patient representative*____

Relationship of patient representative ____

Signature ____ *date* _____/_____/______

Office Use Only: I have attempted to obtain the patient's signature in acknowledgement of the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

Date ____/____/_____ *Initials:* ________ *Reason:*

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