



OFFICE POLICIES

We are committed to your dental care and request that you partner with us by reviewing and cooperating with the following office policies:

Appointments

Your appointment time has been reserved for you. Dentistry at Bridlewood •Stephen H. Dunn & Associates and staff greatly appreciate your effort to arrive approximately 15 minutes before your appointment time so that your medical history, dental insurance, and contact information can be updated on a regular basis. In the event that you have a conflict with your appointment time and must reschedule, we greatly appreciate your courtesy **of at least 24 hours notice** so that we offer your appointment to another valued patient.

Financial Policy

Unless prior arrangements have been made in advance, all fees are due at the time of service. If there are financial concerns, please let us know before your appointment. For your convenience, we accept the following methods as payment:

CASH CHECK DEBIT CARD VISA/MASTERCARD/DISCOVER

We offer third-party financing and upon approval offer interest-free financing options as well as fixed monthly payments options with interest with:

CARE CREDIT LENDING CLUB

Notice of Privacy Policies

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). A copy of this office’s Notice of Privacy Practices is posted in the reception area.

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of recipient: _____ Relationship to patient: _____

Name of recipient: _____ Relationship to patient: _____

I have read, understand and agree to the Office Policies listed herein.

Patient / Guarantor Signature

Date

Insurance Policy - Please read and initial where indicated

As a courtesy to our patients, we bill Dental insurance for reimbursement to the patient for services rendered at our office. Because all providers are out of network with all dental insurance, we do not accept insurance as payment

_____(Initial) Insurance is an agreement between you and your insurance company. Our dental office is not a party to that contract. As such, we can make no guarantee of estimate coverage or payment. We DO NOT have access to negotiated and contracted fees specific to your group plan. Fees are established between the insurance carrier and the company or person purchasing the plan. All providers at this office are out of network with all dental insurance.

_____(Initial) PPOs (Preferred Provider Organizations) are like HMOs in that they have a network of dentists with whom they have a signed contract. Patients may choose a dentist on the PPO list, or choose a dentist outside the "network". Because an "in network" PPO dentist accepts a payment fee schedule, the patient's out of pocket expenses may be higher if he/she chooses to go to a dentist not associated with that particular network. An out of network dentist is under no obligation to accept the PPO fees. The difference may be minimal or large.

_____(Initial) A pre-determination of benefits can be sent on your behalf and per your request prior to beginning treatment. Please note that it will take up to 4 weeks to receive a response from your insurance that determines an estimated calculation of benefits. Pre-determinations are not a guarantee of payment by your dental insurance.

_____(Initial) All HMO's are considered out of network. We cannot bill HMO plans for services rendered at this office.

_____(Initial) **Fees for services are collected in full the same day treatment is rendered.**

It is important for you to have a copy of your policy and some understanding of it. This document is our attempt to avoid any financial misunderstandings. In the end, you are responsible for anything your insurance company does not cover for any reason.

Please complete the information below and present the most current Dental Insurance card for this account. Failure to present accurate and current information may result in claim denial due to timely filing policies set by your insurance company.

Policy Holder's Name _____ Policy Holders DOB _____

Relationship to patient: _____ Social Security # _____

Phone # _____ Employer name _____

Insurance Company _____ Customer service phone # _____

Claim billing address _____

ID Number _____ Policy/group number _____

I have read, understand and agree to the Insurance Policies listed herein. I authorize the employees of Dentistry at Bridlewood to correspond with my insurance carrier to ensure that all claims are processed properly.

Patient / Guarantor Signature

Date