# Belmont Dentistry - Financial Policy

Welcome to our office! At Belmont Dental Care we strive to deliver the finest quality dental care possible. In addition, we are also dedicated to making this top quality care as cost-effective as possible. We will always inform you of what the fee for your treatment will be prior to initiation.

**Payment Options:** Payment for all services is due at the time services are rendered unless an alternate payment agreement has been reached and signed by both parties. To assist you with your healthcare, we offer a variety of payment options including: cash, check, Visa, MasterCard, Discover & American Express. Extended and interest free payment plans (credit approval required) are also available for your convenience.

**Dental Insurance**: As a courtesy we will file your claims and accept assignment of dental insurance benefits. Your policy is a contract between you and the insurance company. Although we may estimate what your insurance will pay, it is your insurance company that makes the final determination on coverage, eligibility, downgrades and coverage amounts. All charges not paid by your insurance company are your responsibility regardless of the reason. Knowledge of policy limitations, waiting periods, etc. is your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of insurance estimates.

**Financial Terms:**

- A $45 fee for appointments that are failed or cancelled **without** 24-hours notice may be assessed.
- In order to reserve time with the doctor for any treatment a reservation fee may be required.
- There will be a $25.00 charge for a non-sufficient funds check
- Any unpaid balances, including insurance, over 60 days are subject to a 1.5% monthly finance charge.

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Signature of Patient/Legal Guardian Print Name Date

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# Health Insurance Portability and Accountability Act (HIPPA)

I hereby give my consent for Belmont Dental Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) as outlined in the Notice of Privacy Practices. The Notice of Privacy Practices describes such uses and disclosures more completely and is available for review upon request.

Belmont Dental Care reserves the right to revise its Notice of Privacy Practices at any time. A revised notice may be obtained upon forwarding a written request to 8350 East Raintree Drive, Suite 115, Scottsdale AZ 85260.

With this consent, Belmont Dental Care may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements or letters.

With this consent Belmont Dental Care may email my home or alternative location any items that assist in carrying out TPO such as appointment reminders and statements. I have the right to request Belmont Dental Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Belmont Dental Care to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Belmont Dental Care may decline treatment to me.

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Signature of Patient/Legal Guardian Print Name Date