

# Carolina Dental Center, R. Jason Meares, DDS, PA

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have reviewed a copy of this office's Notice of Privacy Practices.

### **INSURANCE and FINANCIAL POLICY:**

At **Carolina Dental Center**, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

#### **INITIAL**

\_\_\_\_\_ \*\* Your dental benefits are based upon a contract made between your employer and an insurance company.

**If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans are not meant to dictate treatment** and will never

pay for completion of your dental care. It is only meant to assist you.

\_\_\_\_\_ \*\* We currently bill all private care and commercial insurance plans, except plans that require you to select a dentist

from a list or require our office to accept a reduced fee for service. This means that we work with literally hundreds of insurance companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your

portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to

know your insurance benefit, we can file a "pre-treatment authorization" with your insurance company **at your request** prior to treatment. We charge a \$25.00 fee which is reimbursed to you if treatment is rendered

within 6 months of the pre-treatment submission date. Keep in mind, this is **NOT A GUARANTEE OF COVERAGE OR PAYMENT**. This does delay treatment, but will give you the expected out-of-pocket

expense.

\_\_\_\_\_ \*\* We will bill your insurance as a courtesy. If insurance does not pay within 45 days, we reserve the right to

request payment in full for services from you and let you collect the insurance funds that are due to you. It is

important that you recognize the insurance you have is a legal contract between YOU and YOUR

insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

\_\_\_\_\_ \*\* We require payment in full for your estimated portion at the time of service. We accept VISA, MasterCard,

Discover, cash, and checks. If you are in need of an extended finance option, we also work with Wells Fargo

which offers no interest payment plans designed to meet your dental needs on

approved credit.

\_\_\_\_\_ \*\* A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least 1 business day** advance notice to avoid a **\$40.00** cancellation fee (emergencies are an exception).

\_\_\_\_\_ \*\* We charge a 1½ % finance charge on all unpaid balances over 30 days. In the event a collection agency is needed, you will be responsible for all court costs and associated legal fees. We also charge \$25.00 for returned checks.

I AGREE WITH THE ABOVE CONDITIONS.

PRINT

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_

PATIENT / PARENT

SIGNATURE: \_\_\_\_\_

\_\_\_\_\_

**OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our policies, but acknowledgement could not be obtained because: \_\_\_\_\_ Individual refused to sign \_\_\_\_\_ Communication barrier \_\_\_\_\_ Emergency situation \_\_\_\_\_ Other

Date:

Initials: