DEVEAUX DENTAL CARE CENTER

FINANCIAL POLICY

www.drdeveaux.com

Thank your for choosing our office for your dental care needs. We are committed to successfully treating our patients. Please understand that payment of your account is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please let us know if you have any questions or concerns.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECK, or CREDIT CARD.

Regarding Insurance

We do require that 100% of all related charges, after insurance coverage, be paid at time of service. The account balance is the PATIENT'S responsibility whether or not insurance pays. We cannot bill your insurance company unless you give us current dental insurance information. In the event that we do not accept your insurance, the full amount is due at the time of service. You may pay in cash, check, or credit card. (The same applies to patients with no insurance). All co-pays and deductibles are due prior to the continued service you receive.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Return Check Policy

Whenever a check is written to our office and is returned for Non Sufficient Funds, the patient's account will be charged with a $50.00 Return Check Fee. At that point, check-writing privileges will be lost, however, cash or credit card will be accepted.

Minor Patients

The parent or responsible parties accompanying a minor are responsible for full payment. Due to HIPAA regulations, a minor cannot be treated unless a parent or legal guardians with the proper notarized papers are present at the appointment. The legal guardian that is present with a minor patient will be responsible for all payments due on that day of service.

Missed Appointment

Our policy is to charge $50.00 for missed appointments. Please help us to serve you better by keeping scheduled appointments, or giving 48 hr notice.

I ACKNOWLEDGE BY SIGNING BELOW THAT I HAVE READ THE ABOVE FINACIAL POLICY AND UNDERSTAND IT COMPLETELY. I AGREE TO COMPLY WITH ALL ABOVE STATEMENTS.

_____ _____

Signature of Patient or Responsible Party **Date**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

_____

☐ Other _____
- ☐ E-Mail address_____
- ☐ Cell Phone Texting #

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures make pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures.

We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service your Dental Insurance, are required to comply with HIPPA regulations. List below who you would like your information shared with.

1.)_____ 2.)_____

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Dental Insurance coverage.

Note: Uses and disclosures for The Privacy Officer may be permitted without prior consent in an emergency.

HIPAA POLICY, I _____, ACKNOWLEDGE THAT I HAVE READ THE HIPAA POLICY FOR DEVEAUX DENTAL CARE CENTER.

_____ _____

Signature of Patient or Responsible Party Date

Revised 02/2011