Holmdel Periodontics
and Implant Dentistry

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Welcome to our office.

Please take a few minutes to read and review our office policy form.

We want to thank you for choosing our practice for you dental health care needs and we appreciate the opportunity to provide you with quality healthcare. Our goal is to make you aware of our office financial policies and procedures. Your clear understanding of our policies is important to our professional relationship.

CONSENT TO CARE

I wish to be treated by Holmdel Periodontics and Implant Dentistry. While I am a patient, I permit my doctor(s), the office employees, and all the persons caring for me in the ways they judge are beneficial to me. I understand that this care may include tests, examinations, and dental treatment.

MISSED/CANCELLED APPOINTMENTS

Patients are seen by appointment only. As a courtesy to our patients, we try to confirm your next appointment. A minimum of 48 hours notice is required for canceling an appointment; there is a $75.00 missed appointment fee. Missed appointments are a cost to us, to you, and to the patient who could have used this time slot that was set-aside for you.

FINANCIAL AGREEMENT

We are doing everything possible to minimize the cost of periodontal care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service unless other arrangements have been made in advance. This includes applicable deductibles and co-payments for participating insurance companies. Co-payments are to be paid on the date of service.

If your dental insurance is with a managed care company with which we contract, we are required to follow certain rules and regulations.

These benefit packages provided by insurance companies vary from employer to employer. You need to learn the benefits in your policy and follow the rules of the policy. We will bill the insurance company with whom we participate; however, if we are not paid within 60 days you will be expected to pay the bill in full. Except as provided by contract or state law, you are responsible for all charges.

- please turn page over

Patients with an outstanding balance must make payment arrangements prior to scheduling further appointments. If you are experiencing financial difficulty, please let us know. Often we can defray payments, set-up 3rd party financing or arrange a gradual repayment schedule.

RETURNED CHECKS

COLLECTIONS

As previously stated, all fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered overdue. We will make every effort to arrange an equitable payment schedule. However, if no effort is made to pay the balance due, the bill will be sent to a collection agency. You will be responsible for any additional collection agency fees. In this situation, the responsible person will be asked to seek periodontal care elsewhere.

I have read and understand the above financial policy of Holmdel Periodontics. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility. I agree to keep Holmdel Periodontics accurately informed of my insurance status, and to assign benefits to Holmdel Periodontics as necessary. I authorize Holmdel Periodontics to release pertinent information to my insurance company when it is requested. If it becomes necessary to forward an amount to a collection agency, I will also be responsible for the fee charged by the agency for the cost of the collection, in addition to the original amount due. This may amount to be as much as 40% of the original fee.

RELEASE OF INFORMATION

Holmdel Periodontics & Implant Dentistry may seek, release and verify all or part of the patient's dental and/or financial records to any person, corporation, or governmental agency which is or may be liable under a statue, regulation, or contract to the office, the patient, a family member, or all or part of Holmdel Periodontics & Implant Dentistry's charges.

MEDICAL-AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of dental or medical information about me to be released to the carriers for information needed for claims. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for dentists or organization to submit a claim to insurance for payment.

HIPAA

By signing this form you will consent to our use and disclosure of your health information to carry out treatment, paying activities, and healthcare operations. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, paying activities and health care options.

We welcome you to our office and thank you for your reading and understanding of our policy form.

Signature_____ Date:_____

Witness _____ Date: _____