Kellerman Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. **(Parent or Guardian to sign on behalf of a minor)**

****You May Refuse to Sign This Acknowledgement****

I, ___________________________, have received a copy of this office's Notice of Privacy Practices.
(Patient's Printed Name)

Patient/ Guardian Signature **Date Signed**

This authorization will remain in effect for one year from the above date.

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as 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.**

Payment:
We accept the following forms of payment: Cash, Check, Visa, MasterCard and Care Credit. Payment for services is due at the time services are rendered. When scheduling an appointment for treatment for more than one hour, we may require a 50% deposit of your estimated co-insurance. **Kellerman Dental** reserves the right to withhold 10% of the prepayment for loss of production time if the appointment is failed or cancelled with less than 24 hour notice. The parent that accompanies the minor to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date.

Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are incurred by our office.

Insurance:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within **60 days**, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed. All insurance co-payments and deductibles must be paid at the time of service. You are responsible for providing your current active insurance information.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient/ Guardian Signature **Date Signed**

This authorization will remain in effect for one year from the above date.