SILVER STATE DENTAL Financial & Health Information Policy

Dear Patient:

Thank you for choosing us as your dental provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your oral health. If you have any questions or concerns about our payment policies, please do not hesitate to contact us.

Cash Patients - payment for services are due **at the time** services are rendered.

Insured Patients - co-pays and deductibles are due at the time services are rendered. We accept cash, Visa, Mastercard, American Express, and Discover Card for your convenience. Copayment and co-insurance amount quoted by our office is an estimate; actual amounts may vary and will be determined upon receipt of insurance Explanation of Benefits. We reserve the right to begin billing you directly.

- For treatment appointments, deposit must be made **at the time appointment is scheduled.** (i.e. S.R.P. (deep cleaning) fillings, crown, bridge, etc.) ________ Initial

You have 90 days from the date of service to pay any outstanding balance regardless of insurance coverage. After 90 days, your account is considered delinquent. Delinquent accounts will be turned over to an attorney, collection agency, or other collection processes without notice. Should such procedures become necessary, you will be responsible for all reasonable collection fees, attorney fees and court cost incurred in collection of your delinquent account. All accounts past 30 days shall bear a compounding interest of 3% per month and a late charge of $25 per month.

A fee of $50 will be charged for all missed appointments and appointments rescheduled within 24 hours. ______ Initial

Assignment of Benefits

I hereby guarantee payment of all charges incurred at Silver State Dental. I hereby assign and direct to pay any and all benefits for dental services provided directly to Silver State Dental. I hereby authorize the release of dental information required to process my claim.

I have read and agree to the terms stated in the financial policy and benefits assignment. I understand this assignment applies to all services performed at Silver State Dental and is in effect until specifically revoked in writing. I further agree I will ultimately be responsible for payment for all charges incurred should my insurance company fail to pay.

Patient / Parent / Guardian Signature ____________________________________ Date_____________________

Health Information Policy

I have received a copy of Silver State Dental (SSD) Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand SSD may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time of scheduled appointments, or other dental care related communications.

I understand SSD may disclose health information with other entities, such as my insurance company for purposes of treatment, payment, or business operations.

Patient / Parent / Guardian Signature _____________________________________ Date _____________________

Again, thank you for choosing us as your dental provider. We appreciate your trust in us and the opportunity to serve you.