**FINANCIAL POLICY AND AGREEMENT CONSENT FORM**

Thank you for choosing Happy Smiles for your dental needs. We are committed to providing you with excellent care at affordable prices. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients’ financial capabilities. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your treatment as much as possible.

**Non-Insurance (Cash) Payment:**

Non-Coverage Payments are due in full prior to receiving treatment at the time of service,  
unless prior financial services are made. I agree to be responsible for payment of ALL services rendered on my behalf or my dependents. In the event that payments are not received by agreed upon dates, I understand that a 1½ per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial arrangements are satisfied. Fees that are incurred to collect payments will be billed to and payable by the patient’s account holder. The fee estimate listed for this dental care can only be extended for a period of 6 months from the date of the patient examination. We do offer several payment options:

* **Cash**
* **Visa, MasterCard, Discover, American Express**
* **Care Credit**

**Insurance & Co-Pays:**

Co-Payments vary based on your insurance provider. Our friendly staff will be glad to assist you in letting you know what your co-payment amount is for each of your visits. Our office is committed to helping patients maximize their benefits. If you have any questions, our courteous staff is always available to answer your questions.

* We will always do our best to help you to maximize your benefits.
* Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
* Your treatment plan is individually tailored to your needs and is not based on your dental insurance benefits or lack of benefits.
* Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions to your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.
* Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information, your carrier may need to process your claim. Please, ask if you have any questions.
* As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company’s benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.
* Your claim will be filed immediately, and benefits are expected are to be paid within 30-45 days. The filing of an insurance claim docs does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become “self-pay” and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions Answered to my satisfaction.

I agree to pay for all treatment in a timely fashion as described.

**Refund Policy:**

All payments collected on date of service may be refunded same day. Refunds Request after date of service will be processed within 15 days of refund submission form. Please note ALL PENDING INSURANCE CLAIMS must be paid by your insurance company before a refund may be made.

**Acknowledgement of Insurance Payment Authorization:**

I hereby authorize and direct payment of my insurance benefits to be paid for services rendered directly to Happy Smiles Dentistry. In the event that the insurance company misdirects payment to me, I understand that I am responsible to IMMEDIATELY remit such payment to Happy Smiles Family Dentistry. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

**Notice of Privacy Practices:**

I acknowledge that I have received the practice’s Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for this treatment, payment, healthcare operations and other described and purposes described in the practice’s Notice of Privacy Practices.

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 Patient, Parent, or Legal Guardian Signature Date

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