‘BELLEVUE DENTISTRY’ OFFICE POLICIES AND AGREEMENT

Welcome to our office! We are here to provide you and your family with the highest quality dental care in a friendly and relaxing environment. To keep our standard of care to a level which best serves your dental needs, we ask that you please observe the following guidelines:

Appointments

Our office is open Monday through Thursday from 7am-5pm with a 1 hour lunch break from 1-2pm. We have offset our lunch break to try and accommodate those patients that work during the week and have their lunch hours from 1-2pm. If there are any alterations made to our regular schedule, you will be notified as soon as possible.

Your dental appointment is considered confirmed at the time of booking. This means we are reserving time with our doctor, assistant and/or hygienist, as well as operatory space as required. We will be sterilizing and preparing the operatory space as well as all the equipment and materials required for your procedure. We therefore request that if you are unable to attend the scheduled appointment that you contact our office with *at least* 24 business hours’ notice to reschedule. As a courtesy, we send e-mail and SMS reminders at least two working days prior to your scheduled appointment.

Attendance Policy

As a patient, you play an important role in helping us achieve the highest quality of dental care in a *timely* manner by committing to arrive before/on time for each appointment. Arriving late makes it difficult for us to achieve the goals we have established and scheduled accordingly for that visit. If your arrival exceeds 15 minutes past your start time, we may need to reschedule your appointment. We do understand that traffic can be unpredictable in our surrounding area but, with that said, we ask that you prepare for longer than anticipated travel times.

Patient Initials: _____

Cancellation Policy

There are many times when our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give our office advance notice of their need to cancel a scheduled appointment, this time can in turn, be allocated to those patients in need of urgent treatment. In this way, the office can best serve the needs of ALL patients.

For the benefit of all patients, our office **requires a minimum of 24 business hours' notice if an appointment must be cancelled**. If less than 24 hours' notice is given to cancel an appointment, a minimum **$50.00 fee*** will be assessed depending on the length of the appointment cancelled. In the event that **no notice is given and the patient does not show up for their scheduled appointment, a minimum $75.00 fee* will be assessed depending on the length of the appointment missed**. Please note that insurance companies **DO NOT** cover fees for broken appointments, therefore payment is the patient's responsibility.

***Exceptions will be made for illness or personal tragedy**

Patient Initials: _____

Financial Policy

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) Interest-free payments for up to 12 months and extended payment options for up to 24 months through Care Credit;
2) Flexible payment plans of up to 6 months through our in-house financing option;
3) Cash, Check, or Visa/MasterCard;
4) 5% courtesy adjustment off your balance will be given when services are paid in full at the time of service.

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs; not to match your care to any insurance plan limitations. Dental insurance plans do not directly correlate to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. **Your insurance is a contract between you and your insurance company; therefore, all non-covered charges are your responsibility.** All accounts that are 90 days or more past due will be subject to a 3% interest charge per month.

Patient Initials: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in the treatment directly and indirectly,
- Obtain payment from a third party payer for my health care services, and
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the above address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my provided information may be used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand and agree to the following 'Bellevue Dentistry' policies as listed above:

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

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