First Choice Dental Center
Financial Policy

We are committed to providing you and your family the highest quality dentistry has to offer. In order to assist you with your health care investment, we are providing the following payment options:

Insurance and Co-pay

We will gladly process your insurance claims, estimate your deductible and the portion not covered by your insurance. The estimated amount not covered by your insurance is due in full at the time of treatment and may be paid by any of the options listed below. Our estimates are based on known coverage and limitations provided by your insurance carrier. Patient liability for services is subject to change based on the **actual** payment from your insurance company. We must emphasize that as dental care providers, our relationship is with our **patients**, not their insurance carriers. **You are responsible for any amount not paid by your insurance plan**.

1. **Cash:** includes money orders and personal checks (personal checks not accepted on first visit without time to verify funds / account status).
2. **Visa©/MasterCard©/Discover©/American Express©:** To the extent that your credit limit permits. This includes debit cards with the Visa© or MasterCard logo©.
3. **CareCredit©/Capitol One Financial©/Unicorn Financial© / :** A separate line of credit to cover your entire family's health care needs.
    - Credit line approval can take 10 minutes or less.
    - Interest free options.
    - No annual or membership fees.
    - Monthly payments as low as 3% of the total balance.

Appointments and Cancellations

We understand the value of your time. We make every effort to keep your appointments on their scheduled times to minimize disruptions to your work schedule. We ask that you also place a high value on our time. The doctor's schedule is blocked out for your appointment. No other appointments are scheduled for her during your designated time. We ask that you notify us immediately if you cannot be here for an appointment you have scheduled. If we have ample notice, we can usually fill your spot with another patient needing treatment. Any appointment canceled with less than 24 hours notice from your appointed time (or not showing up for a scheduled appointment) will be charged a $25.00 per hour broken appointment fee. Monday appointments **MUST** be canceled no later than noon on the Friday prior to your appointment to be considered canceled with no broken appointment fee charged. We understand that in emergency situations it is not always possible to notify us within 24 hours. Exceptions can be made to this policy by speaking with the Office Manager.

We regularly call patients a day or two before their scheduled appointment to confirm their time. If you would rather not receive this service, please notify our office staff.

Non Sufficient Fund Checks

A $25.00 fee is charged to all accounts when a personal check is returned for lack of funds in the account. This fee is subject to change, based on our fees associated with a transaction of this nature.

Delinquent Accounts

An account is considered delinquent when a portion of the balance has exceeded 30 days aging. All amounts over 30 days will be assessed a 1.5% charge. Accounts with unpaid balances and no activity for 45 days are subject to be turned over to a collection agency. By signing below I acknowledge that I am responsible for any attorney fees, court costs, and collection fees associated with collecting amounts I owe on my accounts.

Patient Relationship

Just as you have the freedom to choose your health care providers, the doctors have the right to dismiss patient's who refuse recommended treatment, do not comply with treatment regimes, disrupt staff, etc.

By signing below I acknowledge agreement with this policy and accept responsibility for my family's account(s)

_____	_____	_____
Print Name	Date	Signature

FIRST CHOICE DENTAL CENTER
"Where Grins Begin"
3841 Ruckriegel Pkwy, Suite 100
Jeffersontown, KY 40299
(502) 297-8000
www.wheregrinsbegin.com

Notice of Privacy Practices Acknowledgment

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

4. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
5. Obtain payment from third-party payers.
6. Conduct normal health care operations such as quality assessments and physician, dentist, hygienist or staff member certifications.

I have read and understand the *Notice of Privacy Practices* containing a more complex description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* I have received a copy of the current notice today if I so desire. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment, or other health care operations. I also understand First Choice Dental Center is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions.

Initial Appropriate Box(es):(if you do not initial we cannot perform the actions)

☐ I would like voice mail messages left at **home** / **work** for appointment reminders.
☐ I will allow messages to be left with _____ at my home for appointment reminders.
☐ I will allow FAX communications at home / work for my health information. Numbers: _____
☐ I will allow transfer of diagnostic x-rays / charting to dental specialists I am referred to.
☐ I will allow email communication of appointment reminders and account information.
Email address: _____
☐ I will allow postcard notification appointment reminders to my home address.
☐ I will allow the following person(s) access to my medical records to include: release of my records for transfer or review and discussion of treatment planned or treatment completed:
List names_____

Patient Name: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other_____

Signature:_____ Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices, but was unable to do so as documented below:

Date:	Initials:	Reason: