OFFICE FINANCIAL POLICY

Insurance: As a courtesy to our patients, we do bill primary insurance. Please bear in mind that there are many different plans and policies. Your insurance is a contract between you and your insurance company. Some, and perhaps all, of the services provided may not be covered by your insurance company, in which case you will be responsible for the charges for these services. Although we gather as much information as possible regarding your insurance, it is ultimately your responsibility to know which services your insurance policy covers. Insurance is designed to pay only a portion of the cost of your dental needs. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates or benefits. If you have secondary insurance coverage, we will be happy to provide you a claim form to submit for reimbursement. We do not bill secondary insurance.

Payment: Payment is due when service is provided. If you have insurance we will collect from you the amount estimated as your initial responsibility. Any amount not paid by your insurance, in accordance with your policy, is your responsibility and due upon receipt of a statement from our office. Balances carried over 90 days are considered delinquent and will be subject to an 18% finance charge. Delinquent accounts will be turned over for collection and you will be held responsible for collection and/or legal fees. We accept cash, checks, MasterCard, Visa and American Express. We also offer extended financing through CareCredit.

Missed Appointments: Our policy is to charge for missed appointments unless a cancellation is received 48 hours in advance. The charge is $25 per half hour of scheduled time.

I have read, understand and agree to this financial policy.

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Signature of Patient, Parent or Guardian Date

Privacy Policy and Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given me under the Health Insurance Portability and Accountability Act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment for services rendered.
- The day-to-day healthcare operations of our practice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. Any request for restriction must be made in writing. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I acknowledge that I have received the Notice of Privacy Practices from Dr. Chapman's office. In addition to the individuals, professionals, agencies, etc. listed therein, I authorize the release of my private, protected health information to the following: (Please name the person ONLY if you agree to the disclosure):

Spouse _____

Parent/Child/Other family member _____

Other _____

_____

Signature of Patient, Parent or Guardian Date