SUNNYSIDE
FAMILY DENTISTRY

FINANCIAL RESPONSIBILITY

The doctors and all of our staff are committed to giving you superior dental care and we want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan, as well as our financial policy. Carefully read the following, then let us know if you have further questions...

Many people think if they have an employer provided benefit plan (insurance), it is the benefit plan that owes the doctor for their services. This is not the case. The benefit plan contract is between the patient, the employer, and the benefit plan company. As a courtesy to our patients, we'll bill your benefit plan, however, the responsibility for payment will remain with you. In order for us to bill your benefit plan, you must supply us with complete information about your benefit plan, including any necessary forms, group numbers, phone numbers, and addresses.

Most dental benefit plans do not cover 100% of the cost of your treatment. Patients are expected to pay the estimated non-covered portion at the time of service. If your benefit plan has not paid within 60 days of treatment, you will need to pay your account in full to this office. We will then reimburse you if and when your benefit plan has paid. This office can make no guarantees of the benefit plan's estimate of payment. This office does not absolve the patient of full responsibility for the charges in full for treatment rendered.

An often misunderstood term used by many dental benefit companies is "Usual, Customary and Reasonable Fee Schedule (UCR)." This is an arbitrary fee ceiling at which the benefit plan will stop reimbursement. After this ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee we charged, but with the level of coverage negotiated by the employer and benefit plan company.

Patients who do not participate with a benefit plan are expected to pay fees at the time of service unless prior arrangements have been made.

Our fees are on file with Oregon Dental Service.

We accept Visa, MasterCard, Discover American Express cash or check.

All accounts over 60 days will be assessed 1.5% interest per month (18% APR).

There will be a $25.00 fee charged for all returned checks.

If unable to keep your appointments, kindly give us 48 hours' notice. Otherwise, we reserve the right to charge $35.00 for time reserved.

You will need to provide our office with your Social Security number and health insurance card (if applicable) unless your total charge is paid in cash at the time of service. Treatment may be postponed if the above are not furnished by the patient or responsible party.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections on any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the office to release information necessary to secure payment.

Patient's Signature (or Responsible Person, if patient is a minor) Date

Sunnyside Family Dentistry 11808 SE Sunnyside Rd.
503-698-1112 • Fax: 971-224-5027 • info@myclackamasdentist.com

SUNNYSIDE
FAMILY DENTISTRY

AUTHORIZATION & DISCLOSURE (HIPAA)

CREDIT POLICY & FEES DISCLOSURE
ASSIGNMENT OF INSURANCE BENEFITS
AUTHORIZATION TO RELEASE INFORMATION
FINANCIAL RESPONSIBILITY

Truth-In-Lending Disclosure: In accordance with the Federal Truth-In-Lending Act, we are providing the following information about our credit and fee policy:

1. Patient Portion is due at the time of service.
2. Balances extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%).
3. There will be a $30.00 fee charged for cancellations with less than 24 hour notice.
4. There will be a $25.00 fee charged for all returned checks.

Assignment of Insurance Benefits: I hereby authorize SUNNYSIDE FAMILY DENTISTRY to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to SUNNYSIDE FAMILY DENTISTRY.

Authorization to Release Information: I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Financial Responsibility: I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

Authorization to Perform Procedures: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

Print Full Name (Patient or Responsible Person, if patient is a minor) _____ Date of Birth _____

Signature _____ Date _____

Authorization valid until specifically revoked in writing

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