# PATIENT TREATMENT AND FINANCIAL POLICY

Thank you for choosing Royal Care Dentistry as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

**Payment is due at the time service is provided unless another arrangement is made.** Booking a longer appointment time or specialized treatment may require pre-payment ahead of the appointment. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval. Please note: Additional fees will be applied for returned checks. All account balances over 90 days may be subject to a late fee.

**As a courtesy to you, we will help you process all of your dental insurance claims.** Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid.

**All charges you incur are your responsibility, regardless of your insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you,our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. In the event Royal Care Dentistry seeks enforcement of this agreement through the services of our collection agency, Valley Credit Services, the patient/guardian shall be responsible for any expenses including collection costs.

**Minors accompanied by the parent or legal guardian:** The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

**Unaccompanied Minors:** The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

**Missed Appointment(s) and Cancellations:** Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 48 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

**Communications with you:** By signing below, you are authorizing us to contact you at any telephone number and/or email address you provide for any lawful purpose.

## NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT

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:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the right to review such Notice of Privacy Practice prior to signing this consent. I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

**Patient Signature**________________________________________________ **Date**___________________
**Print Name** ____________________________________________________________________________
(Parent/Guardian)