ELDORA
FAMILY DENTISTRY & ORTHODONTICS

FINANCIAL AND OFFICE POLICY

This is an agreement between Eldora Family Dentistry, as creditors, and the patient/debtor named on this form. In the agreement the words “you”, “your”, and “yours”, mean the patient/debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Eldora Family Dentistry.

Payments: Payment is due at time of service. We accept cash, check and credit cards. We also accept CareCredit.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account that month. We shall have the right to cancel your privilege to make charges against your account at any time.

Required Payments: Any co-payments and deductibles required by an insurance company must be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatments for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Finance Charge: A finance charge may be added to your account if not paid within 30 days from date of service.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we need to refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we need to refer the collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Hardin County, Iowa.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit-reporting agency such as a credit bureau.

Returned Checks: There is a $35 fee for any checks returned to the bank.

Missed Appointments: We require a 24-hour notice if you are unable to attend your appointment. After one “no show” we will charge your account a $25 fee. Patients with three missed appointments will be asked to transfer their records to another provider.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we need to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring Records: You will need to request in writing if you want to have copies of your records sent to another dentist or organization. A copying fee may apply. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. In the absence of insurance, other financial agreements may be discussed. Payment of the bill remains the patient's responsibility.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

You have been offered a copy of Eldora Family Dentistry and Orthodontics Notice of Privacy Practices. Please check "YES" to agree. Check "NO" to refuse signing.

YES _____ NO _____

TEXTING SERVICE AGREEMENT

We use a texting service for some patient communications. Please check "YES" to opt in to receive/send text messages. Check "NO" to opt out.

YES _____ NO _____

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect for you, your spouse, family, and anyone on your account.

Patient Name (Please Print): _____

Responsible Party (if not the patient): _____

Signature: _____ **Date:** _____

Our office is HIPAA compliant. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy policies with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.