Cypresswood Family Dental, PA

Michael M. Brymer, DDS

Financial Policy

Cypresswood Family Dental, PA is aware that insurance aids in the acceptance of treatment, but should not stand in the way of proceeding with the procedure(s) that are medically recommended. As a courtesy, we will process insurance claims on your behalf, accepting the assignment of benefits.

We will contact your insurance company to obtain the most accurate coverage of benefits possible. However, quotes are an estimate and could change based upon the payment received from your insurance company.

Payments, deductibles and coinsurance are due at the time services are rendered. For your convenience, we accept MasterCard, Visa, personal checks, cash and money orders. An administrative fee of $30 will apply for all returned checks.

Financial Agreement/Assignment of Benefits/Signature on File

I agree that in return for services rendered by Cypresswood Family Dental, PA, I will pay my account at the time services are rendered or will make financial arrangements satisfactory with Cypresswood Family Dental, PA. I authorize and request my Insurance Company to pay directly to the dentist or dental group. I understand that insurance assignment is accepted for a period not to exceed forty-five days. After that time, I will be responsible for the balance.

I understand that I am financially responsible for any charges not paid by my insurance company. If co-payments/deductibles are designated by my insurance company, I agree to pay them to Cypresswood Family Dental, PA. Accordingly, I accept full financial responsibility for any services not covered by my insurance benefits. I understand that if my account becomes delinquent, it is subject to professional collections and I will be responsible for all costs, including attorney and court fees.

HIPPA Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 the full Notice of Privacy Practices prior to signing this consent and may request a copy at any time. I agree to allow electronic communication as defined in security practices effective April 21, 2005.

By signing below, I acknowledge having read, understand and agree to all the information given above.

Patient Name:_____ **Signature:**_____

Relationship to Patient: (Circle One) Self/Parent/guardian **Date:**_____