Sticka Dental Clinic Office & Financial Policies

FAILED APPTS AND LATE CANCELLATIONS: We require **24-hour advance notice** if you need to cancel or reschedule your appointment. If you fail or don't' give sufficient notice more than one time – we reserve the right to charge a **$50 reschedule fee** which would be applied towards services. If that appointment is failed, the fee is nonrefundable.

PAYMENT FOR SERVICES FOR NON-INSURANCE PATIENTS ARE DUE IN FULL AT THE TIME SERVICES ARE RENDERED. FOR INSURANCE PATIENTS, DEDUCTIBLES AND **ESTIMATED** CO-PAYS ARE DUE THE DAY OF SERVICE. We accept Cash, In-state checks, and most major credit cards as forms of payment.

SERVICE CHARGES: A finance charge of 1.5% per month (18% APR) will be applied to all accounts 60 days or more past due. There is a $30 fee for returned checks. Any fees incurred in the process of collecting payment will be charged to the patient.

INSURANCE: AS A COURTESTY TO OUR PATIENTS, WE WILL VERIFY AND BILL YOUR INSURANCE. But **you are responsible for knowing your benefits** and to provide our office with information necessary to file your claim and receive payment. Deductibles and ESTIMATED co-pays are due on the day of service – but also responsible for any unpaid balance by the insurance company. Any overpayment by insurance will be refunded or applied to future services as requested by the patient.

PROPOSED TREATMENT: We honor fees for proposed services that have been scheduled for six (6) months.

PAYMENT OF BENEFITS: I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the charges for services, and that **I am financially responsible for payment in full of all accounts.** By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payer.

CONSENT: I consent to the dentist's use and disclosure of my records (or my child's record) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to disclosure of my records (or my child's) to the following person(s) who are involved in my care (or my child's care) or for payment of that care. My consent to disclosure of records shall be effective until I revoke it in writing.

ADKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received or was offered a copy of this office's Notice of Privacy Practices (HIPAA).

AGREEMENT: I have read, understand and agree to the above applicable policies, consents and acknowledgements. I attest to the accuracy of the information of this page.