UNDERSTANDING OFFICE POLICY AND INSURANCE RESPONSIBILITIES:

First and most important, we are pleased you have chosen us to care for your dental health. Our goal is to provide the best dental care possible.

It is important we are "up front" with each other as to what our mutual responsibilities are.

OUR PAYMENT POLICIES:

We accept the following forms of payment: cash, check, credit and debit cards. FULL PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED, unless we are billing your insurance company or prior arrangements have been made. Please understand that you, the client or other responsible party are liable for all charges and balances on your account. There will be a $30.00 fee charged for all returned checks, plus the face value of the check. Should it be necessary to refer your account to collections, you agree to pay all the collection costs involved including attorney fees.

If we are contracted with your insurance company, we will honor all of our provisions of that contract. To do this, however, we need your help. If you have changed companies and policies, we must be advised prior to the date we provide service, and give current insurance identification cards and addresses for insurance submission. Otherwise, insurance benefits may be denied or delayed by your insurance company and you there by, immediately become financially responsible for the provided services.

My signature indicates I understand all of the above and I agree to abide by the agreement.

Signature_____Date_____

WE WILL PROCESS YOUR CLAIM AS A COURTESY TO YOU based on the information provided to us by you and your insurance company. You need to be familiar with your policy coverage, benefits, and eligibility.

Deductible amount and fees for non-covered services as determined by your insurance company are the financial responsibility of you, as well as unpaid claims due to lapse or termination of coverage, or delayed payments if incorrect information is provided, or if your insurance company does not process your claims within 30 days.

January 1, 2012, you are responsible for payment after your primary insurance pays. As a courtesy to you, we will still submit primary and secondary insurance and have the secondary insurance pay you directly.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee that your insurance company will pay your claim. You are responsible for payment of your account in full at the end of 30 days after date of service.

I understand that I am financially responsible for the charges not covered by my insurance. I hereby authorize Hicks Dental Group to release any information acquired in the course of my examination and treatment to my insurance company upon their request.

I authorize assignment of benefits from my insurance to be paid directly to Hicks Dental Group.

Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY RIGHTS

I have been made aware of Hicks Dental Group privacy rights policy.

X Signature **Date:**

Print name: **Relationship to Patient**