Willow Bend
DENTAL CARE

Patient consent form (HIPPA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers(e.g. My insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of privacy practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to that date I revoke this consent is not affected.

Signed this _____ day of _____, 20

Print patient's name: _____

Relationship to patient: _____

Signature: _____

Willow Bend
DENTAL CARE

CANCELLATION POLICY

We make all attempts to schedule your appointment in an efficient manner so you will have minimal waiting time upon arrival.

We also expect you to value our time. When you make a dental appointment, you reserve that time for your treatment.

If you need to change or cancel your appointment, we require that you contact us at least 48 hours in advance so that we may use that to treat other patients.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to provide quality care during your schedule appointments, and ask that you give us that courtesy of a call when you are unable to keep your appointment.

We will do our best to remind you for your appointments via emails 2 weeks prior and courtesy calls day before your appointments.

1. 1st missed appointment: We will call and offer to reschedule your appointment
2. 2nd missed appointment: We will call and reschedule you appointment but **you will be charged $30.00 missed appointment fee, which is not covered by insurance and you will be responsible for the balance.**

I understand that if I do not cancel my appointment with in 24hrs prior to my scheduled appointment time, I will be responsible for above fees.

---------- ----------

Signature for the patient/responsible party **Date**

Willow Bend
DENTAL CARE

PAYMENT POLICY:

Thank you for choosing us as your health care provider. We are committed for providing you a quality and affordable dental care. Please read the payment policy. Please ask us any questions you may have and sign in the provided space. A copy will be provided to you upon request.

1. **Insurance/ Discount plan:** We participate in most insurance plans, please refer the list of insurances we are in network with.
   Knowing your insurance benefits and discounted fee schedule is ***YOUR*** responsibility. If you hold dual insurance it is ***YOUR*** responsibility to know which one is your primary insurance. Please contact your insurance company to know your detailed benefits, we can only help you to know.
2. **Copayments and deductibles**: All co-payments and deductibles ***MUST*** be paid at the time of services. Once your insurance has processed your claim and remitted their payment portions, the remainder of the balance, if any, may still be billed to you. This arrangement is part of your contract with your insurance company. ** Beware that insurance coverage percentages may vary from year to year. **
3. **Proof of Insurance and ID**: All patient must complete our patient information form before seeing the doctor. We must obtained copy of your ID or driver's license and current valid insurance information. If you fail to provide us with the correct information, ***YOU WILL*** be responsible for the balance.
4. **Claim submission**: We will submit your claims in timely manner and assist you in any way we reasonably can help to get your claims paid. Please be aware that balance of your claim is ***YOUR*** responsibility whether or not your insurance pays your claim. Your insurance benefit is contract between you and your insurance company; we are not party to that contract.
5. **Coverage changes**: If your insurance changes, please notify us before your next visit so can make the appropriate changes to help you to get your benefits.
6. **Nonpayment**: If your account is over 90 days, you will receive letter stating that you have 30 days to pay your account in full. We accept payment plans upon agreement. Please be aware that if balance remains unpaid, we may refer your account to a *collection agency*.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of usual and customary charges for our area. Being in network provider for your insurance and accepting you as a patient for that insurance, you get in network discount for the services. Thank you for understanding payment policy. Please call us on (847)870-0888 for any questions.

I have read and understand that payment policy and agree to abide by its guidelines:

---------- ----------

Signature of patient or responsible party **Date**