# *FINANCIAL POLICY*

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. **Payments may be made using cash, check, Visa, MasterCard, American Express and/or Discover.** We also offer CARECREDIT, which are financing options that are available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 18% per annum after 90 days.

**Optional payment terms:**

1. **Term Loan**: By arrangements with **CARECREDIT** we can offer patients upon approval, an interest-free term loan (up to 18 months) with no down payment, no annual fee and no prepayment penalty. We have made arrangements with the Care Credit Company to provide payment plans. This allows you to complete your dental work without delay and make relatively small monthly payments. Care credit is used for treatment over $300. Applications are available and approval can be determined within ten minutes. For your convenience you can also apply online at www.carecredit.com or by calling **1(800) 677- 0718**.

As a condition of treatment by this office, **financial arrangements must be made in advance**, and financial responsibility (whether insurance remittance or patient portion) on the part of each patient is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are performed.

**There will be a fee for any additional procedure NOT included in the original treatment plan.**

**Appointments:**

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. When we make your appointment, we are reserving a room for your particular needs. **We ask that if you must change an appointment, please give us at least 24 hours' notice**. This courtesy makes it possible to give your reserved room to another patient who would like it.

***There is a charge for not showing up for scheduled appointments. You will be assessed a $25.00 fee for the second missed appointment, and a $50.00 for the third missed appointment, after which the practice reserves the right to dismiss patients due to repeated rescheduling or missed appointments.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

**Insurance Information:**

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January – December)

**Our doctor will diagnose treatment based on your dental health not your insurance coverage.**

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

***Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.***

You have been/will be given a Treatment Plan Estimate detailing your estimated patient co-pays for any/all prescribed dental work. Insurance remittance estimates are provided as a courtesy and are based on current information collected from insurance carriers. While we would like to advise you of your exact financial obligation before your date(s) of service, the scale of different insurance plan designs make it extremely difficult. **Your co-payment or patient portion may vary based on actual payments made by your insurance provider.**

**Claims for your dental care are submitted on the day treatment is completed. In the event your insurance carrier remits less than the estimated amount of the claim, for any reason inclusive of denied claims, the patient/responsible party, is financially responsible to pay the unpaid balance.**

**Bills for any amount due will be sent to you upon receipt of remittance or explanation of benefits by your insurance company. Payment is due within 10 business days from the date the bill is mailed. If payment is not received by the noted due date, it will be considered PAST DUE and may be sent to collections. Any questions or arrangements pertaining to your bill must be addressed within this 10 day period to keep this account in our office.**

This is your **Health Privacy Notice** from Dr. Michael V. Murphy, D.M.D. **Please read it carefully.**

**Our Legal Duty**
Big Tree Dental and Implant Care like all other medical and dental practices, is required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice.
**Uses and Disclosures of Health Information**
We use and disclose health information about you for treatment, payment, and healthcare operations.
**For example:**
**Treatment:** We may use or disclose your health information to a physician/dentist, dental auxiliaries, students and other healthcare providers providing treatment to you.
**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing or credentialing activities.
**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
**To Your Family and Friends or Persons Involved in Care:** We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.
**Marketing Health-Related Services:** We will not disclose your Personal Health Information to any other company for their use in marketing their products to you.
**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.
**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).
**Patient Rights**
**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a fee for producing dental records and X-rays as allowed by law.
**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). When you pay in full outside of your insurance plan for services you may request that we restrict this information and not disclose it to your healthcare plan or insurer.
**Breach Notification:** We will provide you with notification of a breach of unsecured PHI as required by law.
**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.
**Amendment:** You have the right to request that we amend your health information. This request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
**Questions and Concerns**
If you would like additional information about our privacy practices or have questions, please contact our office directly. We support your right to maintain the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.