IUKA FAMILY DENTAL

Edward S. Knight, D.D.S.
Mark R. Mazurkiewicz, D.D.S.
Tiffany T. Hollingsworth, D.D.S.

OFFICE PAYMENT POLICY AND AGREEMENT

We appreciate your selection of our office to serve your dental health needs. To avoid misunderstanding concerning payment of accounts, please note that PAYMENT IN FULL is required for ALL dental treatment. We will be happy to file insurance claims for you at no extra charge. In addition, you must provide our office staff proper instruction-insurance card, social security number and date of birth of the person you are filing insurance under. The ESTIMATED difference that the insurance does not pay is your responsibility and must be paid the day of each visit.

Your insurance is a contract between you, as a subscriber and/or beneficiary, and the insurance company, involving our office, Iuka Family Dental, PLLC, only indirectly. Therefore, any controversy which might arise over your insurance company's handling of your claim is your responsibility to resolve. Any insurance claim that has not been paid with 45 days of treatment will be billed to you for payment. We are a PPO provider for a select few insurance companies. Please be familiar with your policy. These stipulations also apply to all CHIPS and any other government sponsored insurance recipients.

A quote of expected payment by your insurance does not guarantee payment from your insurance company in that amount; we can only provide an ESTIMATE. You will be mailed a statement after each visit with a final balance. ***ANY ACCOUNT THAT HAS NOT BEEN PAID WITHIN 30 DAYS WILL BE CHARGED A MONTHLY LATE FEE OF $10. ACCOUNTS OVER 90 DAYS WILL BE SENT TO COLLECTIONS AND/OR ATTORNEY.**

( ) I have dental insurance and will pay my portion today.

( ) I do not have dental insurance and will pay in full.

I hereby assign, transfer, and set over to Iuka Family Dental all rights, title and interest to my dental reimbursement benefits under my insurance policy. I authorize the release of any dental information needed to determine these benefits.

This agreement affects all services and charges present and future; and the authorization shall remain valid until written notice is give by me revoking said authorization.

I authorize the verification of my employment by this office or in the event my account becomes delinquent, by any collection agency or law firm to which my account is referred.

I understand I am financially responsible for all charges for my dependents or myself, whether or not they are covered by my insurance. In the event this account is submitted for collections, I, the undersigned agree to pay any and all collection costs and reasonable attorney fees, as well as, the full outstanding balance of charges originally placed with a collection agent.

I, the undersigned, agree to all of the terms stated and promise to pay accordingly.

Guarantor Signature: _____ **Date:** _____

Co-Guarantor Signature: _____ **Date:** _____

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PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights 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 (i.e. your insurance company).
- Conduct normal healthcare operations such as quality assessments and physicians.

Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read the privacy notice and sign this consent.

I understand that I make revoke this consent in writing at any time, except to the extent Iuka Family Dental has taken action relying on this consent.

Patient Name (please print): _____

Signature: _____

If child, Relationship to patient: _____

Date: _____

Please list anyone besides the patient or guardian that has the right to make appointments, discuss treatment or discuss account balances. All other stipulations above apply.

_____

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