Holland Family Dentistry
545 Michigan Avenue, Holland MI 49423
www.hollandfamilydentistry.com
616.396.1058

Financial Information

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

All accounts are due and payable at the time of service. If a procedure requires multiple appointments, payment is required in full at the first appointment. **Payment options include:** Cash, Check, Credit Card, HSA, benefit cards and Care Credit.

New Patients: All new patients require an initial $50 payment at the time of the initial visit. This amount will be applied towards services rendered. After insurance payment has been received if there is a credit remaining that amount will be refunded to you.

Patients with insurance: The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 60 days, we will bill you directly for the full balance. We suggest that you contact your insurance company if they have not paid within 60 days from the date of services. You will need to know the insured's social security number and/or contract number and the date of service. Remember, this is your insurance company and a phone call from you carries more importance than one from our office.

Patients with no insurance coverage: Payment, in full for all procedures will be asked for at time of service.

Fees: all fees are the responsibility of the patient or responsible adult even if you have insurance coverage.

Assignment: I hereby authorize and direct my insurance benefits to be paid directly to Holland Family Dentistry. I understand that I am financially responsible for charges not covered by this authorization. I understand the provider's charge may exceed the insurance payment, and if greater than such payment, I will be responsible for that payment. I also authorize the release of information required for insurance purposes. I authorize the release of information to other providers, upon request, in conjunction with my care and treatment.

Parents not accompanying their child to an appointment must make prior arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$50** charge for changed or broken appointments less than 24 hours in advance. Please note that if you arrive more than 10 minutes late for your appointment there is a chance you may be asked to reschedule your appointment and will not be seen.

I have read the above information and agree to comply with the financial policy of Holland Family Dentistry, P.C.

Signature of **Patient** , if 18 or older	Driver's License #	Date
Signature of **Parent/Guardian**, if patient is a minor	Driver's License #	Date

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy 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 multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party layers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to tome and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Keeping current with the Privacy Rule defined in HIPAA guidelines, we are now requesting written consent for each person(s) that we are allowed to share your Protected Health Information with. Please list the individual(s) below and to be be sure to notify us if this information changes.

- ______________________________ ____________________ ____________________
  Authorized Individual/Person Relationship Date

- ______________________________ ____________________ ____________________
  Authorized Individual/Person Relationship Date

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Patient Name

______________________________ ______________________________
Signature Print Name(if parent/ legal guardian of a minor)

______________________________ ______________________________
Relationship to Patient Date

Child Consent: Parent/ Guardian Verification/ Personal Representative

I, as the parent/guardian of ____________________ a minor child, voluntarily delegate my legal authority to (basic dental care exam, routine annual x-rays, routine fluoride treatment, cleaning, and oral hygiene instruction) on behalf of my minor child to Holland Family Dentistry,

I __________________________ do authorize the following named individual(s) authority to make dental care decisions for the above mentioned minor in my absence:

Name: _____________________________ Relationship to patient:_________________________________

Name: _____________________________ Relationship to patient:_________________________________