Dr. Robert L Smith Jr. DDS Hernando Smiles

Financial Policy

We accept Cash, Check, Visa, MasterCard, Discover and Amex. We have a payment program through CareCredit that you have to qualify for. Your insurance company is a contract between you, the insured, and the insurance company. The dental provider is not part of that contract. As a courtesy and service to you, we will file claims for you. Estimated co-payments and deductibles will be collected at the time of service. If your insurance company does not pay the claim in full, you will be responsible for payment of the remaining balance. By signing below, I understand and agree that I am ultimately responsible for my insurance co-payment, deductible, and any other procedures or fees not paid for or covered by my insurance company.

All balances will be due sixty days from the day of service, despite the actions of your insurance company. Monthly statements will be sent keeping you informed of the status of your account. We will refer your account to a collection lawyer for any balance that remains ninety days from the date of service. We reserve the right to add additional collection fees up to 40% of the balance submitted to the collection agency and reasonable attorney fees.

Signature of Parent, Patient or Guardian _____

Date _____

HIPAA

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 (HIPAA). I understand by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Dental Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (i.e. 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 HIPAA. 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 healthcare operations, but that you are not required to agree to these requested restrictions.

Signature of Parent, Patient or Guardian_____

Date _____

Circle which form of contact is ok for you and family members to be contacted:

TEXT EMAIL PHONE MAIL