# Elite Smiles Financial Policy & HIPAA

**HIPAA Privacy Authorization:** We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so.

I Furthermore acknowledge that I have the right to authorize access and disclosure of my protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual (s):

Print Name _____ Relationship_____

Print Name _____ Relationship_____

I Request the following restriction (s) to release my PHI:

_____

**Cancellation Policy:** If you are unable to keep your scheduled appointment for any reason, you will notify the office at least 48 hours in advance of your scheduled appointment time. Please note that scheduled changes will be accepted only during regular office hours. We reserve the right to charge a fee if you don't provide 48- hours' notice of cancellation or do not show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $50. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment.

**Dental Insurance**: We accept most major dental insurances and as a courtesy to our patients we file claims with dental insurance company for the services rendered. We do not file claims with the secondary Insurances & BCBS Federal Plans. If there has been any changes in your insurance during the time being, It will be your responsibility to notify the front desk to update your information.

**Payment methods:** We accept Visa, Master, Discover credit & Debit cards, Cash, Checks. Care Credit financing options available.

Payment is due in full at the time of service. (Total payment for self-pay patients and estimated copay for insured patients) Insurance coverage is only an estimation. You are responsible for payment of any balance due not paid by your insurance company. After 30 days, if your insurance has not paid your claim, you are responsible for full balance.

After 60 days, accounts with an unpaid balance will incur a 1.5 % interest per month. Accounts will be sent to collections if there is an outstanding balance past due 90 days. Any fees incurred from the Collection agencies will be added to the patient's account balance. Please help us avoid this by paying promptly.

### By Signing below, I understand and agree to these policies.

Patient Signature _____ Date_____

Parent or Guardian Signature _____ Relationship_____

Date_____

Revised 9/21/18