middleton smiles
Family Dentistry

Financial & HIPAA Agreement

Patient Name (First, MI, Last)_____ Date of Birth:_____

Payments

Payment is due at time of service. If you are interested in a payment plan, please discuss pre-arranged payment options with our front office staff before starting treatment. We accept Cash, Credit, Check, Care Credit, LendingClub, and OrthoBanc.
Returned checks are subject to bank fees and a $25 service fee.

Insurance

As a courtesy, we will submit your claim to your insurance carrier for you. *Your estimated co-pay/coinsurance is due at time of service.* For your information, insurance companies often "downgrade" treatment to a lower service as a way to save on their reimbursement. In the event insurance does not pay, you are responsible to pay for any remaining balances on the account.
All quotes are estimates only and cannot guarantee payment from insurance companies.

Hometown Dental Plans

Our Hometown Plans are discount programs offered by Dr Ganir for our patients with no insurance to help make preventative care and treatment more affordable. Hometown plans are offered at a discounted rate off our standard pricing and *payment for all treatment and plans are due at the time of service*. Please feel free to inquire at the front desk for details

Account Balances

If you fail to fulfill any financial arrangements or obligations, interest will be applied on past due balances at a rate of 1.5% per month. Accounts become past due at 90 days and will be sent to collections thereafter. If account is sent to collection, all legal fees become your responsibility.

Appointment Cancellations

If you must change appointments, we require 24 hours' notice to avoid a $50.00 cancellation fee.

Credits and Refunds

Accounts that have been over paid by the patient have the opportunity to have their credit refunded or to keep the credit on their account for future treatment. If you would like your credit returned to you, please notify our front desk.

PAYMENT, INSURANCE & FINANCIAL POLICIES

I verify that the identification & information I have provided is true and accurate and will update this office as changes occur. By signing below I acknowledge that I received and red the Financial Policies form and agree to abide by such policies.

Signature:_____
Relationship to patient:_____ Date:_____

Notice of HIPAA & Privacy Practices

By signing this form, I give consent to Middleton Smiles to use and disclose my protected health information in order to carry out treatment, payment and healthcare operations. With my consent, I understand that Middleton Smiles may communicate with me via phone & text, mail, email. I have the right to restrict how this communication is made and will notify our office accordingly. Please refer to Middleton Smiles Notice of Privacy Practices for a more complete description of such uses and disclosures.

**Please list individuals whom we have permission to speak with regarding dental treatment and financial accounts for this family account.

_____ _____
Name Relationship Name Relationship

Notice of Privacy Practices (must be signed by ALL New Patients).

I have been offered, understand & agree to the Notice of Privacy Practices for Middleton Smiles in compliance with the Health Information Portability and Accountability Act of 1996 ("HIPAA").

Signature:_____
Relationship to patient:_____ Date:_____