THREE RIVERS OFFICE POLICIES:

_____**Privacy Practices**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the office manager. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. Please ask if you would like our staff to explain your HIPPA rights.

_____**Insurance**: We are an in-network with Delta Dental Premier and Delta PPO Plus Premier only. As a courtesy to our patients, we will submit all claims to your insurance company. We do our best to determine estimates, covered benefits, and expenses. However, because each policy is different, it is ultimately up to the patient to check with their insurance to determine the covered and allowed benefits. Any portion of treatment not covered by the insurance is the responsibility of the patient.

_____**Payment**: All deductibles, co-pays, and patient portions determined to be not covered by insurance are due at the time of the service. Patients without insurance are expected to pay for treatment at the time treatment is rendered, unless otherwise previously determined by the office manager.

_____**Payment Plans**: As a courtesy our office offers third party financing payment plans. If you are interested in using financing as a type of payment, please ask our staff for more information.

_____**Delinquent Accounts**: Should your account be in delinquency for over 30 days, it will be placed into collections. The patient is responsible for the legal and collection fees, as well as the total amount owed toward the account, and any interest it has acquired. The patient will not be seen in our office until the account is in good standing. If you are experiencing financial hardship and fear your account cannot be paid at this time, please contact our office manager.

_____**Broken Appointments**: Our office reserves the right to charge a fee of $75-$200 for missed or cancelled appointments, depending on the length of time reserved for the appointment. To avoid any fee, our office requires notice of at least ** **TWO BUSINESS DAYS****. If multiple appointments are broken or missed, we may require a deposit be placed prior to reserving another time slot for you.

_____**Appointment Reminders**: Our office sends appointment reminders via text messaging, email, and phone calls. If you do not wish to receive reminders please contact our office manager.

_____**Blood Pressure**: Many people have high blood pressure and do not know it- there are often no symptoms until a stroke or heart attack occurs. In 2008 20 million Americans saw their dentists, but not their physicians, making the dental appointment an important and (maybe the only) opportunity to check blood pressure. All patients 20 years of age and older screenings will be done here every 6 months -1 year.

Consent: I have read, understood and agreed to the above policies for patient privacy and financial obligations. I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist or dental group. I understand that the care rendered to me by the doctor is based on my dental needs and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature:_____