

Office and Financial Policy

Full payment is expected at the time of service, unless arrangements are made prior to treatment.

MISSED APPOINTMENTS

There is no charge for rescheduling an appointment provided that 48 hours notice is given. Otherwise, a minimum charge of **\$20 per half hour** missed will be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.

PAST DUE ACCOUNTS

Be advised the policy of this office is that interest of 1.5% per month (18% Annual Percentage Rate) will be applied to all accounts over 60 days, regardless of the insurance involvement. Any delinquent accounts will be referred to Court for legal action. There will be a collection fee of 33.3%, and/or court cost and reasonable legal fees should this be required. You understand if this account is submitted to an attorney, collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, that fact that you received treatment at our office may become a matter of public record

RETURNED CHECKS there will be a \$50.00 handling fee for any checks returned by the bank.

INSURANCE ACCEPTANCE

Please remember that your policy is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. You are ultimately responsible for your bill, and you will be required to pay for any services not paid by your insurance.

Because all insurance policies vary, there may be a portion of your visit that insurance will not cover. Please understand that you will be required to pay for the difference or co-pay the day of your service. We are a participating provider with United Concordia, Delta Dental Premier, and Group Dental. Please be advised that if Dr. Cottrell's office is not a participating provider of your insurance company, that you are responsible for portions not paid by your insurance. If you have a deductible on your dental policy, you must pay the deductibles on services it applies to, in addition to your portion not paid by insurance. The estimate provided by this office is considered as a guideline until the final insurance payment is received. We can make no guarantee of the insurance payment as estimated. We submit claims as a courtesy to our patients. They will be submitted promptly after treatment is rendered. If claims are not paid by the patient's insurance company by the 61st day after treatment it will be billed in full to the patient.

DIVORCE

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

INSURANCE REIMBURSEMENT ON FILLINGS

This office only uses Resin (tooth colored) fillings. Most insurance companies will reimburse for Amalgam (silver) filling price if a Resin procedure was done. We will bill you for the difference of the

Resin filling after the insurance payment has been received. If you have any questions please ask the front desk or Dr. Cottrell.

POLICY ON BLOOD BORNE AND INFECTIOUS DISEASE

By the nature of our profession, the dentists, hygienists, and assistants are routinely exposed to blood and body fluids during the treatment of patients. In accordance with Section 32.1-45.1 of the Code of Virginia, Dr. Cottrell requires that if an employee is exposed to body fluids in a manner that may transmit blood borne or infectious disease, both the employee and the patient will be tested for disease.

FINANCIAL/OFFICE CONSENT

I agree to be fully responsible for my account. I will pay for services as they are rendered. I have read and understand that by signing this form I am agreeing to the terms and agreements listed.

Patient's Signature

Date

NOTICE OF PRIVACY PRACTICES

Purpose of consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. You may obtain a copy of the Notice of Privacy Practices by contacting Heidi Barnett at Dr. Cottrell's office

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I have full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature/Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representatives Name: _____ Relationship: _____

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____ Date: _____