CONSENT FOR SERVICES, APPOINTMENT AND PAYMENT POLICIES

Patient Name:_____ Birthdate: _____

Bliss Dental is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

Broken or cancelled appointments

If you need to cancel an appointment, please notify us at least 72 hours in advance for Tuesday through Saturday appointments and no later than2:00pmThursday for Monday appointments. We charge $50.00 for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give 72 hours notice so we can discuss this with you. Please do not cancel an appointment with a voicemail message. Instead, please talk to us during office hours to avoid confusion.

Office Surveillance

Please be advised that all activities within the office are under continuous audio and visual surveillance and recording. We adhere to all HIPAA guidelines as related to these recordings and all office records.

Payment is due at the time of treatment

Payment for treatment is due in full at the time of treatment unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements. However, payment is due at the time of service for the Initial Emergency or Limited appointments.

Insurance claims

If we file an insurance claim for you, you will need to pay us at the time of treatment the expected estimated insurance deductible and any estimated amount that we expect insurance will not cover.

We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted, and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits.

Your Right - Copy and/or Transfer of your Records

You have the right to inspect and copy your health information and related records, by filling out our release authorization form, records will be sent within 10 days of the receipt of your written request and receipt of the administrative fee. For providing an electronic or paper copy of your health information, we will charge you an administrative fee in responding to your request.

Returned checks

Please take every precaution to avoid giving us a bad check. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments

Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account interest at the rate of 1.5% per month (18% annually) for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

Collection costs

We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 45% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

Regarding Minors in the office

Minors MUST ALWAYS be accompanied by an adult; the adult accompanying a minor will be responsible for payment of services on their appointment. If parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims. I agree to the above policies and charges.

X _____ Date: _____

Signature of patient or responsible person

Name of patient: _____

Name of person responsible for patient charges, if different: _____