Insurance Agreement

To our patients who are requesting that this office carry a balance on their account, to be paid by an insurance company.

This form must be read and signed by the patient or responsible party before we can accept payment directly from an insurance company.

1) I understand and agree that I am responsible for the payment of all treatment fees on my account, if my insurance company fails to pay within 30 days, I will be responsible for the full amount and all collection fees.

2) I understand and agree that the amount estimated to remain unpaid by the insurance is to be paid by me during the treatment.

3) I understand that this office cannot make a totally accurate estimate of the insurance benefits to be paid for me, since it does not have access to all insurance company records.

4) I understand that after the insurance company pays, there could be a balance still remaining to be paid by me.

5) I understand and agree that if upon payment by the insurance company, there is a remaining balance; it is due to be paid in full by me. Due within 30 days.

6) I understand and agree that if the estimate of insurance benefits indicates a large amount due by me and I feel I cannot pay it during the time of treatment, I can request a written financial agreement (terms to be discussed at the time).

7) I understand and agree that financing beyond three months cannot be handled by this office.

Signature of Responsible Party _____ Date _____

Office Manager _____

Family, Cosmetic, & Implant Dentistry

Dental Excellence & Compassionate Care

Appointment Policy Agreement

James Island Family, Cosmetic & Implant Dentistry is committed to providing all of our patients with exceptional care. When a patient cancels without giving sufficient notice, they prevent another patient from being seen.

Please call us at 843-795-1111 48 hours prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Thursday*.** If prior notification is not given, you will be charged $65 for the missed appointment.

Please sign below to consent to these terms.

X _____

Patient's Signature (Patient's Parent/Guardian if under 18)

Please provide the best way to confirm this appointment:

Email or Phone call or Text _____

****ALL APPOINTMENTS MUST BE CONFIRMED*****

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

*** You May Choose Not to Sign this Acknowledgment***

I, _____, acknowledge that I have reviewed the Notice of Privacy Practices for James Island Family, Cosmetic, Implant & Periodontal Dentistry. I have read and understand how my protected health information is used and/or disclosed for purposes of treatment.

I authorize James Island Family, Cosmetic, Implant & Periodontal Dentistry to speak to the following person(s) concerning my appointments and/or treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that the person(s) listed above will be required to provide some form of identifying information of mine (DOB, SSN, ect.) to facilitate communication. I understand that this Authorization does not designate permission to release my protected health information in writing. I can revoke this Authorization at any time by writing to: Office Manager, James Island Family, Cosmetic, Implant & Periodontal Dentistry, 531 Folly Road, Charleston, SC 29412

_____ _____

Patient Printed Name | Patient or Parent/Guardian Signature

_____ _____

Signatory Relationship to Patient | Date

OFFICE USE ONLY:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the Authorization
- ☐ An emergency situation prevented us from obtaining the Authorization

Team Member Initials _____