Hanson Family Dentistry
Financial Policy/Privacy Practices Consent

All **payments** are expected, in full, on the day that treatment is rendered. If you are a patient with Dental Insurance we will, **as a courtesy**, file your dental claim and allow up to 45 days for payment.

Please be advised, that dental insurance may only pay for a portion of your treatment. Your insurance benefits are determined by your employer, **not your dentist**. Benefits may be reduced by deductibles, co-pays, and usual, customary, and reasonable limitations. Hanson Family Dentistry will estimate the payment amount expected from your insurance but be aware **it is only an estimate and NOT a guarantee of payment**. Y**ou are ultimately responsible for all fees generated as a result of your treatment.** Any special payment arrangements are to be agreed upon prior to your treatment appointment. It is your responsibility to inform Hanson Family Dentistry with any changes to your insurance information.

Payment options: We accept Visa, Mastercard, cash, and personal checks. Third party checks are not accepted. We will assist you with outside financial options such as CareCredit. There will be a **$45.00** fee for all checks returned by your bank for insufficient funds.

You will be responsible for all costs of collecting, or attempting to collect any debt owed on this account. This includes all attorney's fees, interest, and late fees.

Minor children under the age of 18, are to be accompanied by a parent or legal guardian at all times and that person will be financially responsible for the minor.

Appointment Policy: Appointment times are reserved exclusively for you. Hanson Family Dentistry reserves the right to charge and collect a minimum of **$49.00** for any broken appointments**. Broken appointments** are considered those that are missed (no-show) and/or cancelled less than 2 **business days** in advance.

I authorize the dental staff of Hanson Family Dentistry to perform any necessary dental services, which I may need during diagnosis and treatment, with my informed consent.

I have read and understand the above financial policy. Signature: _____

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing the Consent.

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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat or continue treating you if you revoke this Consent.

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

_____ _____

Signature Date