SNODGRASS-KING
PEDIATRIC DENTAL ASSOCIATES

FINANCIAL GUIDELINES & HIPAA STATEMENT

We wanted to take a moment to thank you for your support and loyalty to our dental practice. We continue to grow because terrific patients like you are referring your family and friends. Here at Snodgrass-King we make it our priority to deliver the highest quality of dental care to all of our patients. To ensure that we are able to accommodate everyone, we have established new missed appointment and financial guidelines. We appreciate your cooperation as we continue to serve your family's dental needs. You are the reason we are here, and you are very important to us. Thank you for your trust in our dental practice.

For your convenience our Cool Springs, Murfreesboro and Spring Hill offices are open Monday-Thursday from 8am to 5 pm. Friday from 7 am to 11 am. Our Mt. Juliet office is open for pediatric patients Monday and Thursday 8am to 5 pm and Friday 7am to 11am while continuing to serve our adult patients Monday through Friday. Our Hermitage office is open Tuesday and Wednesday from 8 am to 5 pm. Before seeing the staff we ask that the patient information and insurance forms be completed. **Please be advised that payment is due at the time service is rendered.** We accept **CASH, CHECKS**, and the following **CREDIT CARDS**: **MasterCard, Visa, American Express, Discover, CareCredit**.

REGARDING INSURANCE:

FIRST VISIT: Since insurance companies reimburse at different rates, we only ask that you pay the estimated percentage of your co pay set forth by your insurance company.

ESTIMATED COPAYS FOR RESTORATIVE AND SEDATION APPOINTMENTS: As a courtesy to our patients we will file your insurance for any restorative work that you need, but we will collect the co pay in advance. For our patients of **general or cosmetic dentistry** we do require that **1/2 of your estimated co pay be paid on the date the appointment is booked, and the remaining 1/2 at the time the services are rendered. Patient will be responsible if there is a difference** (i.e. a down grade from composite (white) to amalgam (silver) fillings.) the option for nitrous and/or oral sedation is available, **but payment in full will be required at the time of service.** We can also send a Pre-Determination claim for anything over $300; this process takes about 4-6weeks.

FEES FOR MISSED OR BROKEN APPOINTMENTS: Unless cancelled or rescheduled within 24 HOURS PRIOR to the appointment time, your account will be charged $50.00 for each missed hygiene and/or orthodontic appointment. A broken appointment fee for adult restorative services is $75.00 this applies to Adult patients only In order to book your next appointment; these fees are to be paid in full. This is not something we want to do; however it has become necessary. If there have been a total of 3 or more same day cancellations or broken appointments we will not schedule any further appointments.

FEES FOR LATE APPOINTMENTS: Every effort will be made by our office to see you at the scheduled appointment time. We expect that same courtesy. If you are more than 15 minutes late for a scheduled appointment, you may be asked to reschedule. We do not want to encroach upon someone else's time or have you rushed through your appointment.

I HAVE READ AND FULLY UNDERSTAND THESE GUIDELINES AND STATEMENTS GIVEN TO ME BY SNODGRASS KING PEDIATRIC DENTAL ASSOCIATES AND ACKNOWLEDGE BY SIGNING BELOW.

HIPAA NOTIFICATION AND CONSENT TO TREAT A MINOR: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act.1996 (HIPAA). I understand that my signing this consent, I authorize you to use disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), Obtaining payment from third-party payers (e.g my insurance company), the day-to-day healthcare operation of our practice. I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

PERMISSION TO TREAT: Since your child is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and all necessary dental services can be performed by Snodgrass-King Pediatric Dental Associates, P. C I, being the parent or guardian of the above minor patient, do authorize and request the performance of dental services for this patient; and the performance of whatever procedures Snodgrass-King Pediatric Dental Associates. P.C. may deem necessary during the performance of any procedures. Furthermore, I will be responsible financially for any bill incurred for this patient for dental treatment; including any attorney or court fees in the event it becomes necessary to place this account in collectibles.
Thank you for understanding our financial guidelines. Please let us know if you have any questions.

Patient: (printed name)_____

Patient or Guardian Signature: _____

Date: _____