Office Policy

On behalf of all our staff, welcome to our practice! We are pleased that you have chosen us to care for your dental needs. We are committed to providing you with the highest quality of oral health care in the most gentle, efficient manner possible. We value your time, therefore, unless an emergency occurs, you can expect us to be on time with your appointments. In order to achieve these goals, we have enforced the following policies:

- Insurance is a contract between you and your insurance company. We are not a party to this contract. All patients will be responsible for all dental charges, if their dental insurance has not been verified prior to their visit. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of you eligibility.

- You agree to pay any portion of charges not covered by your insurance. All co-payments, deductibles or portions not covered by insurance must be paid in full as services are rendered.

- PAYMENT OPTIONS: CASH, CHECK, CREDIT CARDS (VISA, MC, DISCOVER, AMEX) OR CARE CREDIT

- Reserved appointment time in our dental office is limited and valuable. It is extremely important that all patients honor their reserved appointments. Failure to either keep your appointment or to notify our office within 24 house of a cancellation will result in a <u>$25</u> charge to your account. No further appointments will be made until the above charge has been paid in full.

- <u>Finance Charge</u>: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty days ago, and then subtracting any payment or credits applied to the account during that time. The minimum finance charge is $.50.

- <u>Returned checks</u>: A fee of $40.00 will be assessed for any checks returned by the bank.

• **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be Miami-Dade County, Florida.

• **Waiver of Confidentiality:** Your understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

• **Transferring of records:** You will need to request in writing, and pay $25 copying/admin fee if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. All requests must be in writing and allow 48 hours to comply.

• **Photographs:** I consent that photographs may be taken of me or parts of my body. The photographs shall be taken by my dentist or by a photographer approved by my dentist. The photographs shall be used for dental records and if in the judgment of my dentist, dental research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of dental education, knowledge, or research; provided, however that if it is specifically understood that in any such publication or use, I shall not be identified by name. The aforementioned photographs may be modified or retouched in any way that my dentist, in his/her discretion, may consider desirable.

I acknowledge receipt of Notice of Privacy Practice.

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Signature **Date**