Bear Creek Dentistry & Orthodontics

FINANCIAL RESPONSIBILITY STATEMENT

Patient Name _____

Responsible Party _____

Relationship to Patient _____

Financial Policy:

1) Payment in full is expected at the time of treatment.
2) Patients with dental insurance are expected to pay their estimated co-pay at the time of treatment.
3) VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS and CASH are accepted.
4) Long term financing is available through CARE CREDIT (Synchrony) and Lending Club, upon completion of a credit application and approval.
5) Balance over 90 days old are charged an 18% APR service charge monthly.
6) WE reserve the right to charge for appointments cancelled or not kept without 24 hours' notice. The fee is $50.00 per appointment, Saturdays and lengthy appointments are higher.

To Our Patients with Dental Benefits:

Dental Plan Name _____ **Group #** _____

It is our pleasure to help you file your insurance claims forms or take assignment on your dental benefits as designed by the dental plan indicated above. We provide this service at no additional coast to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the Plan Sponsor determines that you are not eligible at the time of service, or makes a determination that you are eligible for reduced level of coverage, by signing this agreement, you do hereby agree to financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor.

_____ _____

Signature of Responsible Party Date

Bear Creek Dentistry and Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,

but acknowledgement could not be obtained because:

__Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge of $50 for not showing up to your scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Patient (Parent/Guardian) Signature _____ Date_____