



NOELCK & MA FAMILY
— DENTISTRY —

PATIENT FINANCIAL POLICY, INSURANCE AGREEMENT AND HIPAA CONSENT

(Please review the following financial responsibilities, insurance benefits, and privacy rights policies carefully.)

FINANCIAL POLICY

PAYMENT RESPONSIBILITY:

Payment for services rendered is ultimately the responsibility of the patient or responsible party.

Payment is due at the time services are rendered unless prior financial arrangements have been made.

We accept Personal Checks, Cash, Visa, Mastercard, Discover, American Express, and CareCredit.
Deposits & Payment Arrangements:

- Major treatments including crowns, bridges, dentures, and partial dentures require a 50% deposit to schedule treatment. The remaining balance is due at the time of delivery/completion.
- Any treatment involving laboratory services requires at least 50% payment at the initial appointment.
- Orthodontic treatment requires a \$1,400 down payment prior to treatment. The remaining balance will be divided into equal monthly payments at 0% interest and automatically charged to a valid credit card kept on file throughout treatment.
- Patients with multiple broken or failed appointments may be required to pay a 50% deposit before future appointments may be scheduled.
- Patients without insurance may inquire about our in-office membership plan.

APPOINTMENT & CANCELLATION POLICY:

We kindly request at least two (2) business days notice for appointment cancellations or rescheduling.

- Missed appointments or cancellations without proper notice will result in a fee of \$50 per hour of scheduled treatment time.
- Patients arriving more than 15 minutes late without prior notice may be considered a missed appointment and subject to the same fee.
- Missed appointment fees are not billable to insurance and are the patient's responsibility.
- Future appointments may not be scheduled until outstanding missed appointment fees are paid.

OUTSTANDING BALANCES:

Balances unpaid after 90 days from the date of service may be subject to a finance charge of 1.5% interest per month.

Parents or guardians accompanying minors are financially responsible for payment regardless of divorce decrees or custody arrangements.

INSURANCE AGREEMENT & DISCLAIMER

As a courtesy, our office will assist in filing primary and secondary insurance claims. Please note: Regardless of insurance coverage, the patient/responsible party remains fully responsible for all balances related to services provided.

- Noelck & Ma Family Dentistry is a network provider only for Delta Dental Premier.
- We are not contracted with other insurance companies but are happy to work with most PPO dental plans.
- Insurance benefit information provided by our office is only an estimate and is not a guarantee of payment.
- Dental insurance is a contract between the patient, employer, and insurance company.
- Patients are responsible for understanding their dental benefits, limitations, exclusions, waiting periods, and annual maximums.
- Estimated copays and deductibles are due at the time of service.
- If insurance pays more than expected, any overpayment will be refunded to the patient.
- If insurance does not pay within 60 days of service, the outstanding balance becomes the patient's responsibility.
- Any filing of secondary insurance after 60 days becomes the responsibility of the patient.
- If requested before treatment begins, we can submit a predetermination/preauthorization to your insurance company. Please note this process may take approximately 6-8 weeks and is not a guarantee of payment.

NOTICE OF PRIVACY PRACTICES & HIPAA CONSENT

This notice describes how medical and dental information about you may be used and disclosed and how you can access this information. Our Responsibilities: We are required by law to:

- Maintain the privacy and security of your Protected Health Information (PHI)
- Provide you with this Notice of Privacy Practices
- Follow the duties and privacy practices described in this notice
- Notify you in the event of a breach involving unsecured PHI

We reserve the right to change our privacy practices as permitted by law. Updated notices will be available in our office upon request.

HOW WE MAY USE OR SHARE YOUR INFORMATION:

- We may use or disclose your PHI for:
 - Treatment
 - Payment
 - Healthcare operations
 - Appointment reminders by phone, text, email, or mail
 - Public health and safety requirements
- Legal obligations
- Family members or caregivers involved in your care/payment
- Business associates supporting our practice
- Workers' compensation, research, and national security purposes when permitted or required by law

We will not sell or use your information for marketing or fundraising purposes without your written authorization.

If you pay in full out-of-pocket, you may request that information regarding those services not be disclosed to your health plan.

YOUR RIGHTS:

- Access and obtain copies of your records
- Request corrections to your records
- Request restrictions or confidential communications disclosures
- *File a complaint without retaliation
- *Receive a copy of this notice
- *Receive an accounting of certain disclosures

Requests must be submitted in writing. Reasonable fees may apply for copies of records.

QUESTIONS OR COMPLAINTS:

For questions regarding privacy practices or to file a complaint, please contact:

Noelck & Ma Family Dentistry at 623-935-1155 Or contact:

Office for Civil Rights, U.S. Department of Health & Human Services - Toll-Free: 1-800-368-1019 or TDD: 1-800-537-7697
200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201

PATIENT ACKNOWLEDGMENT & CONSENT

By signing below, I acknowledge and agree that:

- I have read and understand the Financial Policy, Insurance Agreement, and Notice of Privacy Practices.
- I understand that insurance estimates are not guarantees of payment.
- I understand I am financially responsible for all balances not covered by insurance.
- I authorize Noelck & Ma Family Dentistry to submit insurance claims on my behalf.
- I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations as described above.
- I acknowledge that I received or was offered a copy of the Notice of Privacy Practices.

Patient/Responsible Party Signature: _____ Date: _____