The Office of Lauren Standefer, D.D.S. and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit. While we will do our very best to outline your insurance plan to you, ***it is ultimately your responsibility to know your insurance plan benefits and restrictions.*** Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. It is important to remember that your insurance policy is a contract ***between you and your insurance company***. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are ***your sole financial responsibility***. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. ***They are not a guarantee of payment to us***. We ask that you pay your co-payment, deductible, or any balances at the time services are rendered. If you are unable to pay your estimated portion for that time, we ask that you make prior financial arrangements with our billing representative or through our other payment option Care Credit.

If you do not have dental insurance, by signing this statement you acknowledge that you understand that you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18%annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.** If during the admission or application process I have provided a cell phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account should it become delinquent.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to the office of Lauren E. Standefer, D.D.S. I agree to give the office of Lauren E. Standefer, D.D.S. permission to contact me regarding appointments and/or treatment at the phone number provided. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I certify that the information I provided here is true and correct.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature _____ Date: _____

Employee Signature: _____

Continue Next Page→

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information

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Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available.

Uses and disclosures of health information: We use and disclose health information about you for treatment payment, and healthcare operations.

Patient Rights: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request, unless we cannot practically do so. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you a $25 administration fee plus $5 per page for records.

I agree to have my dental history, health and/or treatment options discussed with those listed below:

_____

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Signature: _____ Date: _____