Financial, Insurance Benefits & Privacy/HIPAA Policy

Financial Policy:

Payment Options:

- Cash, Check, Credit Card (Visa, MasterCard, American Express, Discover)
- We offer a 5% courtesy discount to our patients without dental insurance [1]
- We work with Care Credit Healthcare Credit Card[2] to offer convenient payment plans

Please note: Tetrick Family Dentistry requires payment upon the completion of your treatment.

Cancellation Policy: Our office requires 24 hours notice to cancel or reschedule appointments. Missed appointment and appointments cancelled within 24 hours are subject to a $50.00 failed appointment fee.

Insurance Benefits:

For patients with dental insurance, as a courtesy we are happy to bill your insurance company. However, it is your responsibility to know and understand your dental benefits and to update us with any changes regarding your dental insurance coverage. Any amount not paid by your insurance is your responsibility.[3]

For insured patients having major restorative work performed, a deposit is required prior to billing your insurance.

Privacy/HIPAA Policy:

Tetrick Family Dentistry maintains compliance with HIPAA's privacy policy. A Statement of Privacy Practices is available for review upon request.

I authorize Tetrick Family Dentistry to disclose my Personal Health Information to the following people. [Please include spouse and/or family members as applicable.]:

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[1] Payment is required on day of service to receive the non-insured discount [2] Subject to credit approval [3]If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

I have reviewed the Financial, Insurance Benefits & Privacy/HIPAA Policy and I have been offered the HIPAA Statement of Privacy Policies to review. Additionally, I authorize any insurance payments made on behalf for services provided to be paid directly to Tetrick Family Dentistry.

Patient Name _____ Date _____

Patient Representative Full Name _____ Patient Representative Signature _____ Date _____

Patient Signature _____ Date _____