



OFFICE PROCEDURES AND POLICIES

Thank you for choosing Anderson Smile Studio, the office of Dr. Lori Anderson, DDS for your dental care. Our goal is to provide for you a pleasant and relaxing environment along with the finest dental care possible. We strive to educate you about your diagnosis and treatment alternatives as well as your financial options. We hope that this policy will help you understand our office procedures and financial policies.

PAYMENT

Payment is expected the day dental services are provided. For your convenience, Master Card, Visa, Discover, AMEX, checks and cash are accepted. We will provide a written Treatment Proposal that will detail your diagnosis, treatment alternatives, estimated insurance coverage (if applicable), and your estimated portion due at the time you begin treatment. No procedure performed on the human body can be guaranteed, as such, payment is due and fees non-refundable regardless of treatment outcome. Payment for services rendered is also required if you decide to abandon a course of treatment in favor of an alternative form of treatment.

DENTAL INSURANCE

As a courtesy to you, we accept and will file most primary dental insurance plans. Please provide us with your identification card. Dental insurance is not intended to be a “pay all” service but is intended to help reduce your “out of pocket” expenses. We do NOT accept assignment of benefits for secondary insurance. Therefore any balance remaining after your primary insurance has responded is due in full. As a courtesy, we will prepare a secondary insurance claim form and submit it on your behalf when you have paid your account in full.

INSURANCE PAYMENT

As a courtesy to you, we will file your primary insurance claim and we are willing to wait up to 30 days from the date of service for payment. If payment has not been made, we will contact your carrier and strive to resolve any reason for delay. If unable to immediately resolve the situation, a statement will be sent to you for immediate payment by the responsible party. Thereafter, we will gladly assist you in attempting to obtain direct reimbursement from your carrier. WE MUST EMPHASIZE that our relationship is with you and not your carrier. Our primary concern is for your well-being and we structure our care accordingly. Insurance companies determine benefit packages and payment rates (usual and customary or UCR) by the plan type that

is purchased by the employer/insured party, not by the level of care provided by Anderson Smile Studio. All changes including interest, accrued from the date services are rendered are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof.

APPOINTMENTS

We value your busy schedule and strive to see patients at the appointed time. We ask you to extend the same courtesy. Whenever possible please provide a minimum of 48 hours advance notice when requesting scheduling changes or cancellations so that we can arrange care for other patients experiencing urgent dental needs. Failure to give adequate notice may result in a \$75.00 office fee placed on your account that must be paid prior to rescheduling.

RETURNED CHECK FEE

A fee of \$35.00 or the charge attached to our account for the returned check will be charged for any returned check. The entire outstanding balance and returned check fee must be paid immediately upon notification from Anderson Smile Studio.

ACKNOWLEDGEMENT, RELEASE AND AUTHORITY

I, as the patient, or as the authorized guardian or responsible party for the patient named, consent to all treatment as necessary or desirable, including but not limited to drugs, medicines, performance of clinical treatment, labs, imaging or other studies that may be performed, ordered or used by Anderson Smile Studio. I authorize Anderson Smile Studio the use and release of any protected health information, as defined in the Health Insurance Portability and Accountability Act (HIPPA) and in the manner described here within to third party payees or other health practitioners as reasonably necessary for my treatment, and/or for proper reimbursement. I further hold harmless Anderson Smile Studio from any and all damages resulting from the reasonable use thereof. I also give my consent to be contacted regarding my dental health, treatment, and scheduling and account information by telephone, email, postcard, newsletter and/or letter. I authorize and request my insurance company to pay Anderson Smile Studio any monies due me as reimbursement for services rendered by Anderson Smile Studio. I understand my insurance company may pay less than the charges incurred on my behalf or on behalf of those for which I am responsible. I permit a copy of this authorization to be used in the place of any previous agreements or arrangements.

I agree to pay triple damages if I cash any insurance or other check that represents reimbursement to Anderson Smile Studio for services rendered and I fail to immediately tender the monies due to Anderson Smile Studio. I agree and understand in the event I do not pay Anderson Smile Studio the balance due and my account is placed with a collection agency and/or an attorney for collection proceedings, I will be legally responsible for all costs of collection, including to but not limited to collection agency fees, including those derived as a percentage of outstanding balances, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Anderson Smile Studio, and I further consent to the jurisdiction of the Small Claims Court, or Superior Court of Maricopa County, Arizona and agree that Arizona law governs all matters arising from this agreement.

I further understand that a 1.5% finance charge per month (18% per annum) will be added to my account for any balance over 30 days, regardless of pending insurance claims. I certify that any information I have provided today is correct to the best of my knowledge. I also understand that it is my responsibility to inform Anderson Smile Studio if the patient is a minor and that I am certifying that I am his or her legal guardian.

I have read the above conditions of treatment and payment, and I agree to its content.

Signature of guarantor of payment/responsible party:

Signature: _____ Date:

Relationship to Patient:
