Hillis Family Dental | Amanda M. Hillis, D.D.S.

OFFICE CONSENT FORM

Policy on Patient Responsibility

Date:________________ Patient Name:_____________________________

Financial Responsibility

Thank you for coming to Hillis Family Dental! We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions or problems with our fees or payment process, please do not hesitate to contact our front desk at 636-970-7902.

We require that our patients promptly pay all charges that we present to them. In some cases our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you promptly pay the entire charge we present to you, even if your issue with the program is not resolved.

Payment for our services is due at the time that those services are provided for you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things, copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or government programs. We may also present charges to you by written statement via the mail following a visit. If we do this, we expect that each charge will be paid in full by return mail within 15 days the first time it is presented to you. We or our agents may send you statements and reminders of charges made and amounts that we believe must be paid, or may call you about the same. By accepting our services, you are consenting to receive these communications.

I authorize Hillis Family Dental and its collection agency to contact me, or a representative I appoint, about my account, including using contact information or cell phone numbers that I have provided or will provide, or that is available to Hillis Family Dental from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages, even if I am charged for the call under my phone plan. I agree such contact will not be “unsolicited” for purposes of local, state, or federal law. I agree that Hillis Family Dental and its collection agencies may monitor and/or record any communication.

I authorize the dentist to perform treatment and administer medication that may be indicated in connection with the dental care of the below-named patient and further authorize and consent the dentist choose and employ such assistance as he/she deems fit. I agree to be responsible for all charges for dental services and materials rendered by this office. If for any reason this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees.

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Date **Signature of Responsible Party**

HIPPA Authorization

I have been given the opportunity to read and review a copy of the Privacy Policy. I authorize you to discuss my treatment, including diagnoses, treatment options, associated costs, actual treatment performed, information from my health history, including medications I am taking with the following individuals:

NAME:______________________________ Relationship:_____________________________________

NAME: ______________________________ Relationship: ____________________________________

NAME: ______________________________ Relationship:_____________________________________

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Date **Signature of Responsible Party**

Assignment of Insurance Benefits

I hereby authorize payment of the dental benefits otherwise payable to me, to be paid directly to Dr. Amanda M. Hillis, D.D.S. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment will be considered as an original. I understand that I am financially responsible for all charges for services rendered by Dr. Amanda M. Hillis, D.D.S., and Hillis Family Dental, whether paid by my dental benefits plan or not. To the extent under applicable law, I hereby authorize release of all information to secure payment of my claims or my dependent's claims.

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Date **Signature of Responsible Party**

Cancellation Policy

I understand I will be charged a $25.00 cancellation fee for all missed appointments without giving notice within 24 hours.

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Date **Signature of Responsible Party**