CORNERSTONE DENTAL GROUP

Financial Agreement

Our office understands the value of insurance benefits, and we are happy to assist you in filling the necessary forms. This is done as a courtesy to our patients and there is no guarantee of coverage. The insurance carriers base the amount of benefits on a fee schedule that they arbitrarily develop. For this reason, you may receive less of a benefit than we estimate for you. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. Our patient coordinators will make every effort to help you maximize your insurance benefits.

Once your insurance carrier has paid, you will be responsible for any difference upon receipt of our statement. If for any reason your insurance carrier has not paid within 60 days from the date of treatment, you are responsible for the entire balance at that time. In addition, the unpaid balance may be subject to an 18% annual percentage rate (APR) interest charge. In the event of default, legal interest on the indebtedness, collection costs (which could be as high as an additional 50%) and related attorney's fee could also be added.

Cancellation Agreement

Our office requires 24 hour notice for any cancellation. This is so we can allocate other patients in need of urgent dental care. A $50.00 fee will be charged if less than 24 hours notice is given. This fee is entirely the patient's responsibility, and is not covered by your insurance.

Payment Agreement

Payments are expected at the time services are rendered. Payment and charges made at the time of services are estimates until your insurance carriers and the provider have made the appropriate adjustments to your account. Insurance companies may deny your claim, at which time you are responsible for the entire balance.

We accept the following: MasterCard, Visa, American Express, Discover, Cash, Check, or CareCredit. We do not offer any in-house finance options.

I understand my financial obligation as outlined above and I am aware that any balance outstanding after 60 days is my responsibility.

_____ _____

Patient/ Responsible Party Signature Date

_____ _____

Team Member Witness Signature Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

*Protected health information may be disclosed or used for treatment, payment or health care operations

*The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

*The Practice reserves the right to change the Notice of Privacy Policy.

*The patient has the right to restrict the use of their information.

*The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

*The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

This HIPAA Consent/Sharing was signed by:_____ Date:_____

Relationship to patient (if other than patient):_____