DENTAL HYGIENE DIRECT

PRACTICE OF JESSICA L. WOODS, RDHAP

Welcome to our practice! We are excited to have you as a lifelong patient. It is our goal to provide you with the highest quality of dental hygiene care in a courteous and effective manner. In order to achieve this goal, we ask that you read and agree to the following practice policies:

APPOINTMENTS

Our practice is dedicated to quality care and exceptional service. Our team spends extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $50.00 will be charged for every hour of allotted time cancelled to your credit card on file.

TREATMENT

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our practice we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is usual and customary for the service area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance benefits. We will be sensitive to your financial circumstances and do everything possible to help you achieve optimal oral health. Ultimately however, you are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates (UCR).

The insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. We are happy to submit the claims necessary so that you receive the full benefits of your coverage; however we cannot guarantee that the estimate of coverage will be reimbursed in full. Please know that we will do everything possible to see that you receive the full benefits of your policy by filing your claim the day of your appointment so that your insurance company will reimburse you directly in a timely manner. If there are any complications, we will assist you with any information you may need.

FINANCIAL POLICY

Payment for services is due at the time services are rendered unless prior arrangements have been made. For you convenience, our practice accepts the following forms of payments: cash, check and most major credit cards. If you choose to pay by check, and it is returned to our office for any reason from your financial institution you are subject to a $35 returned check fee, in addition to the returned check amount. This fee covers the processing fees that are charged to our office. Should your account become delinquent for more than 60 days, a finance charge of $50 or 5% per month will apply, whichever is greater. If your account should be referred to an attorney or collection agency, the undersigned shall be responsible for all additional fees incurred in the collection process.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have.

MEDIA RELEASE

Photographs, audio and/or video recordings may be used as a record of your care and may be used in the following formats, but not limited to: lectures, seminars, demonstrations and professional publications. Your name and other identifying information will be kept confidential, however should these types of media be necessary to submit insurance claims, your identifying information may be required.

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TERMS AND CONDITIONS

As a condition of treatment by Dental Hygiene Direct, I understand financial arrangements must be made in advance. The practice depends on the reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental hygiene services, or any dental hygiene service performed without prior financial arrangements, must be paid for at the time services are rendered.

I understand that the dental hygiene services provided to me are charged directly to me and that I am personally responsible for payment of all dental hygiene services. If I carry insurance, I understand that as a courtesy Dental Hygiene Direct will help prepare my insurance forms to assist in making collections from my insurance company(s) and will credit such collections to my account. However, the dental hygiene practice does not prescribe nor render services on the assumption that charges will be paid by my insurance company.

ASSIGNEMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to my dental benefits accrued to me under my policy. I understand that the fee estimate listed for this dental hygiene case can only be extended for a period of 30 days from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by Dental Hygiene Direct, I agree to pay therefore, the value of said services to Dental Hygiene Direct at the time services are rendered. I further agree that the value of said services shall be billed unless objected by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this practice or I institute any legal proceedings with respects to amount owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurring including reasonable attorney's and/or collection fees.

I grant my permission to Dental Hygiene Direct to telephone me at home, work, or mobile and/or via text and email to discuss matters related to my dental care.

I have read the above conditions of treatment and agree to their content.

_____ _____

Signature of Patient/Power of Attorney Date

NOTICE TO CONSUMERS: DENTAL HYGIENIST ARE LICENSED AND REGULATED BY THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA | (916) 263-1978 | WWW.DHCC.CA.GOV

Insurance Information

Subscriber Name: _____

Subscriber DOB: _____ Subscriber ID/SS#: _____

Insurance Company: _____ Policy Number: _____

Group Name: _____ Group Number: _____