New Kent Dental Care

Patient Policy

Our financial policy has been established to ensure that the best services can be provided to you and your family. We make every effort to curb the cost of your dental care and keep fees aligned with what is considered usual and customary for our area. You can assist us by keeping your scheduled appointments and by paying at time of service to cut down on billing costs.

Insurance

We will do our best to give you a rough estimate of your investment in your dental health. The amount quoted to you is only an ***ESTIMATE*** and not a guarantee of payment from your insurance. Due to constantly changing insurance contracts, benefits, and deductibles, we are only able to estimate your insurance coverage.

Your insurance is a contract between you and your employer/carrier. To avoid any confusion please make sure your insurance company will allow you to visit us. As a courtesy to all of our patients we will file dental claims to your insurance on your behalf. In order for us to do so, we ask that you provide us with all necessary insurance information. We are happy to assist you in utilizing your dental benefits.

Not all services are covered benefits in all contracts. Some insurance plans have stipulations, limitations, and/or contingencies that we are not aware of. You may want to become familiar with your coverage benefits by using your Benefits Booklet or by contacting the member services number on your card. We will gladly provide you with a treatment plan that includes the dental codes for recommended treatment procedures so that you may call to inquire about your coverage.

You are fully responsible for all fees that you incur in our office regardless of insurance coverage. Co-pays, deductibles, and any co-insurance percentages are due as services are rendered. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason. Insurance plans may bundle codes, downgrade, pay at an alternate benefit, or may have a LEAT clause (Least Expensive Alternate Treatment). Your treatment plan is based upon your individual needs. It is not based on your dental insurance benefits.

Pre-treatment estimates may be sent to your insurance as a courtesy. Please be aware that it does not constitute full or final payment for any treatment scheduled. Your insurance company may have exclusions for services or waiting periods. It is not a guarantee of coverage. While we may be listed as a participating provider with an insurance company, we may or may not accept their contracted fees for specific plans. We are happy to assist you in answering questions you may have. We may ask that you allow us time to decipher how your insurance plan works or to present us with your Benefits Booklet.

Appointments

We make every effort to be on time for our patients because we respect the value of your time. We ask that you please extend us the same courtesy.

Please keep us up to date with any changes to phone numbers or email addresses, as we utilize automated confirmation systems. If you have not heard from us and are unsure about an upcoming appointment, we may not have your current information. Please call us to ensure that the contact information we have on file is correct.

Should you need to make a change to your appointment, we require 48 hours notice. Please allow us adequate time to offer the opening to another patient in need of treatment. Any changes to an

appointment must be made by calling the office, preferably during business hours. Please **do not** send messages regarding changes to appointments through the automated system. We may not receive your response.

We reserve the right to charge a broken appointment fee. The minimum charge is $75.00. The length of the appointment time will determine the amount of the charge. This also applies to failed appointments. Again, please make sure your contact information is current with our office.

Collections

We reserve the right to apply a finance charge of 1.5% on all accounts 60 days overdue. Any account balance over 90 days is subject to further collection action. In the event the account is referred for legal action, a collection fee of 35% of the account balance will be added to your balance to cover the costs incurred by us to recover your debt plus any processing, legal, or court fees.

Payment Methods

We accept payment by Cash, Debit, or Credit Card.
For extended payments we offer CareCredit.
All major treatment involving a laboratory procedure will require an appropriate down-payment and must be paid in full by delivery date.
If your treatment plan requires several visits you will be given an estimate of you financial obligation and asked to discuss and sign a definitive financial agreement.

I have read and understand the terms of this agreement.

Print Patient Name _____

Signature (Patient or Parent/Guardian) _____

Date _____

Dental X-Ray Policy of New Kent Dental Care

Just as primary care physicians require periodic blood tests to evaluate a patient's health, dentists must rely on periodic Dental X-rays for the detection and accurate diagnosis of a variety of oral health conditions. Many dental problems are not readily visible from an external examination. These X-rays have become so important to the early diagnosis and treatment of dental disease that they are considered as part of the "Standard of Care" to which all licensed dentists must adhere. Only pregnancy and a few other medical conditions may allow patients to opt out of dental X-rays.

While in the past, some dental offices allowed patients to sign forms declining X-rays, this is no longer allowed under the "Standard of Care." ADA guidelines state the need for periodic dental bitewing X-rays. In addition, every 3-5 years a more extensive Panoramic X-ray of the jaws or full mouth series showing each entire tooth should be taken. X-rays may also be deemed necessary for diagnosing oral problems.

We will be glad to talk with you about specific concerns you may have such as; safety, cost, or discomfort from x-rays. While it is a right for patients to refuse X-rays, patients refusing X-rays will no longer be scheduled or treated at New Kent Dental Care without required X-rays. The practice will provide emergency treatment for a period of 30 days following refusal of X-rays.

By signing this form, I confirm that I have read and understand the dental X-ray policy at New Kent Dental Care and that any questions have been addressed.

Please sign on appropriate line below:

X-rays accepted: _____ Date: _____

X-rays declined: _____ Date: _____

Witness: _____ Date: _____

New Kent Dental Care

Office, Dental Insurance Information and Financial Policies

Dear Patient:

Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We would like to welcome you and your family to our dental family.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. Please consider the option that works best for you.

♦**Dental Insurance**-If you have dental insurance, as a service to you, we will complete your insurance form with all the necessary information and submit it to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____(please initial)

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

♦If your insurance company has not made a payment within 30 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship).

♦**Payment is due at the time treatment is rendered.** We accept Cash, Personal checks, Master Card, Visa Card, a debit card or Care Credit.

♦**Monthly payments**- If you need to make long-term payments we can offer financing with Care Credit. You must qualify to use this option. Or we can offer a two-month payment plan with a credit card on file.

All patients with an outstanding balance will receive a statement each month. There is a finance charge of 1.5 % (18% APR) on all accounts 60 days overdue. If you have a returned check you will be charged a return check fee of $50.00 per check.

We reserve the right to charge for appointments broken with out proper 48 hours notice. The length of the appointment scheduled will determine a charge for the broken appointment. There is a minimum charge of $75.00 for a broken appointment cancelled with less than 48 hours notice.

SIGNIFICANT EXPOSURE- Section 32.1-45,1(A) and (B), Code of NC. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and /or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

Minor Patients- The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, a MC/VISA, cash or check, payment is paid on the account at the time of service.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill and my family member's bill _____ (names of the family member's) including co-pays, deductibles or non-covered services requested by me. In lieu of a refund, I authorize any credits on any family member's account to be transferred to any family member's account balance and I understand I will be billed for any outstanding balance after the credit is applied to the outstanding balance/s unless otherwise directed. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges incurred to collect this account) on the principal balance of 18% (eighteen) per annum from the date of service. In the event the account is turned over to collections you will need to discuss all payment arrangements with our attorney.

_____ _____

Signature of patient, parent or guardian Date

rev. 6/14

New Kent Dental Care
2690 Dispatch Road
Quinton, Virginia 23141
804-932-4940

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, {Please Print Name} have read a copy of this office's Notice of Privacy Practices.

_____{Signature}_____{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____*Individual refused to sign*
_____*Communications barriers prohibited obtaining the acknowledgement*
_____*An emergency situation prevented us from obtaining acknowledgement*
_____*Other (Please Specify)*_____

PERMISSION TO ACCESS DENTAL RECORDS

I, _____(PATIENT NAME) give permission to the following people to access my dental records-

_____(PATIENT, PARENT OR GUARDIAN SIGNATURE)

_____(DATE)

1. _____ Name
_____ Relationship
_____ Telephone Number
2. _____ Name
_____ Relationship
_____ Telephone Number
3. _____ Name
_____ Relationship
_____ Telephone Number

****List person(s) we have permission to discuss you, your account, your appointments, or your treatment/care with.*****