FINANCIAL POLICY

Thank you for choosing Bluffton Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

You can choose from:

-Cash, Check, Visa, Mastercard or Discover.

-NO INTEREST[1] Payment Plans[2] from CareCredit

- Allow you to pay overtime with NO INTEREST[1]
- Convenient, low monthly payment plans[2] also available
- No annual fees or pre-payment penalties

PLEASE NOTE:

Bluffton Dental Care requires payments prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier.

A FEE STARTING AT $100 For Hygiene and starting at $500 for Doctors schedule. IS CHARGED FOR PATIENTS WHO MISS OR CANCEL APPOINTMENT WITHOUT 24 HOUR NOTICE.

BLUFFTON DENTAL CARE CHARGES $45 FOR RETURNED CHECKS.

If you have any questions, please do not hesitate to ask.

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Patient, Parent or Guardian Signature

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Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed form purchase date. Minimum monthly payment required.

[2]Subject to Credit approval

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my dependent during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Signature ____
(Of Guardian if patient is a minor)

OFFICE USE ONLY

Written Acknowledgement could not be obtained because:

_____Individual Refused to Sign
_____Communication Barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

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