Please read and sign at the end of
of this form to acknowledge that you
were informed of our office policies.
Please feel free to ask a team member
if you have any questions or concerns.

# Katherine V. Hicks, D.D.S., P.C. Office and Financial Policy

Thank you for choosing Katherine V. Hicks, D.D.S., P.C for your dental needs. Dr. Hicks and staff are committed to providing you with the highest quality of care. This following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice. We ask that you please review and confirm with your signature below. All billing is completed as a courtesy to our patients on behalf of their dental insurance provider. Patients are financially responsible for all dental services.

## PATIENT RESPONSIBILITY

Each patient must complete a health history document upon becoming an established patient, it is the patient's responsibility to let Dr. Hicks and her staff be aware of the most accurate and updated allergies and or medical conditions that could impact dental care. At your first visit with our office, we expect you to supply us with your insurance information. Should any changes occur, it is the patient's obligation to supply our office with the most up-to-date, correct information.

## INSURANCE

Although we are participants of many insurance companies, it is **ultimately your responsibility to confirm Dr. Hicks is in fact a provider for your particular insurance.** We will submit a claim for payment for your services to your insurance as a courtesy, **but you are responsible for any copays or deductibles not covered by your insurance.** These are collected at time of service. If you are billed for any balance, payment is required within 30 days of receipt of a bill. Secondary insurance claims are filed as a courtesy, and become the responsibility of the patient if any payment is not received within 60 days of filing a claim. **It is your responsibility to be aware of your benefits with your insurance.** If your insurance information, copay, or coverage has changed at any time during your treatment, it is your responsibility to notify the office with the most current and up-to-date information. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

## ESTIMATES AND FEES

If a treatment plan is created upon examination and necessary x-rays, you are entitled to and **encouraged** to ask for an estimate of fees for treatment. All estimates are based upon conditions viewed at the time of diagnosis: unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimate. It is customary to pay for dental services when they are rendered.

## PAYMENT METHODS

For your convenience, acceptable forms of payments are; cash, check, VISA, MasterCard, Discover, and American Express. If no payment is received on account after one monthly statement, an interest charge will occur. After two monthly statements, our office will make every effort to contact the Responsible Party. If the Responsible Party can not be reached, a third bill will be sent indicating this is the final notice for payment. Please note, if a personal check is returned for insufficient funds, there will be a $25.00 fee added to your account.

## FAILED OR CANCELLED APPOINTMENTS

If an appointment has been reserved for you, we kindly ask that patients provide at least a 24 hour notice to cancel an appointment; otherwise, we reserve the right to charge a minimum of $50.00 for a broken appointment fee.

## DELINQUENT ACCOUNTS

Delinquent accounts will be turned over to a credit reporting collection agency.

Please read and sign at the end of
of this form to acknowledge that you
were informed of our office policies.
Please feel free to ask a team member
if you have any questions or concerns.

## BILLING INQUIRIES

If you have any questions regarding a bill you have received from our office, please feel free to contact us at (520)323-3866. Our office hours are Monday, Tuesday, Thursday 8:00-5:00, Wednesday 8:00-12:00, excluding national holidays. Thank you for allowing Katherine Hicks, DDS to be an important part of your dental care. For any further questions or concerns, our staff is available to assist you.

## NOTICE OF PRIVACY PRACTICES

A laminated copy of our office Notice of Privacy Practices (HIPPA) is available in our office, as well as a link to view online. You have the right to read our Notice of Privacy Practices before you agree to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations. Of the uses and disclosures, we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

## ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to Katherine V. Hicks, D.D.S., P.C.

**Signature of Patient/Legal Guardian: _____ Date: _____**