FINANCIAL POLICIES

Insured Patients
Patients with insurance are asked to pay the deductible and estimated patient portion at the time of service. Please keep in mind the estimated portion is just that, an estimate. Filing insurance claims is a courtesy we extend to our patients.

Non-Insured Patients
If you do not have dental insurance we ask for payment in full at the time of service. If you feel financial arrangements are necessary you may discuss this with the front office staff before treatment is started.

No- Show/Cancellation Policy
Your visit has been reserved for you. If you are unable to keep your appointment we require 48 hour notice for cancelling or re-scheduling. A fee can be assessed without such notice.

Usual and Customary Rate (UCR)
Our practice is committed to providing the best treatment possible for our patients. Our fees reflect the usual and customary rates set for our area. Keep in mind the rates paid by your insurance carrier are determined by the insurance carrier and your employer and have no bearing on the usual and customary rates charged for our area.

Divorces
Both partners are responsible for the debts incurred up to the date of the divorce decree. The parent who requests treatment for a child is responsible for the balance of services rendered.

Late and Finance Charges
A finance charge will be imposed on those charges not paid in full within 90 days of the day treatment was rendered. The amount of the late charge will be as authorized under the laws of Washington.

Emergencies
Should you experience a dental emergency after hours, please call our office. The recorded message will provide an after hour emergency contact number

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have read the copy of the Statement of Privacy Practices for the office of Safe Harbor Dental (laminated sheet behind paperwork, please ask for a copy if you wish. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the office.

Safe Harbor Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority:
In addition to the allowable disclosures described in the statement of privacy practices, I specifically authorize disclosure of my protected health care information to the persons indicated below **(please mark all that apply)**

Spouse only	( ) Yes	( ) No
Any member if immediate family	( ) Yes	( ) No
Message on home or cell	( ) Yes	( ) No
Message with work	( ) Yes	( ) No
Email	( ) Yes	( ) No

Signature of acknowledgment: _____

Date signed: _____