FINANCIAL POLICY

ALL FEES FOR DENTAL SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. ALL PATIENTS ARE EXPECTED TO PAY THEIR FULL BALANCE AT THE TIME OF THE VISIT. IT IS NOT ALWAYS POSSIBLE TO PREDICT WHICH SERVICES ARE COVERED BY YOUR INSURANCE CARRIER OR HOW MUCH THEY WILL PAY FOR A PARTICULAR SERVICE. AS A COURTESY TO OUR PATIENTS, WE CAN FILE DIRECTLY WITH CERTAIN INSURANCE CARRIERS, EVEN THOUGH THE FEES FOR DENTAL SERVICES ARE DUE AT THE TIME THE SERVICE IS RENDERED. PLEASE UNDERSTAND THAT IF YOUR INSURANCE CARRIER DOES NOT REMIT PAYMENT WITHIN 30 DAYS, THE ACCOUNT REVERTS TO A SELF-PAY STATUS AND THE FULL BALANCE IS OWED BY YOU. SHOULD AN INSURANCE PAYMENT EVER BE MADE DIRECTLY TO YOU, YOUR BALANCE WITH THE CLINIC SHALL BE DUE IN FULL IN 10 DAYS. THERE WILL BE A $5.00 MONTHLY REBILLING CHARGE FOR ANY BALANCE OVER 30 DAYS. IF PAYMENT IS NOT RECEIVED WITHIN 45 DAYS, YOUR ACCOUNT IS SUBJECT TO BE SENT TO COLLECTIONS. RETURNED CHECKS WILL BE FINED $25 PER INCIDENCE, PLUS ANY BANK RETURN FEES. CHECKS WRITTEN FROM A CLOSED BANK ACCOUNT WILL BE CHARGED UNDER FELONY CHARGES FOR THEFT OF SERVICES. ANY COURT COSTS THAT HAVE ACCRUED WILL BE OWED BY YOU.

SIGNATURE____ DATE__________________

MISSED APPOINTMENT POLICY

I UNDERSTAND THAT A **24 HOUR NOTICE** MUST BE GIVEN IN THE EVENT THAT I AM UNABLE TO KEEP MY SCHEDULED APPOINTMENT TIME. FAILURE TO GIVE THIS REQUIRED NOTICE WILL RESULT IN A $25.00 PER HOUR MISSED APPOINTMENT FEE.

SIGNATURE____ DATE__________________

COLLECTIONS POLICY

I AGREE THAT KING FAMILY DENTAL CARE, OR ANY OTHER COLLECTION OR SERVICING AGENCY RETAINED BY KING FAMILY DENTAL CARE TO COLLECT MONEY THAT I OWE THE FACILITY, MAY CONTACT ME BY TELEPHONE OR TEXT MESSAGE AT ANY NUMBER GIVEN BY ME OR OTHERWISE ASSOCIATED WITH MY ACCOUNT, INCLUDING CELLULAR/WIRELESS TELEPHONE NUMBERS WHICH MAY RESULT IN MY INCURRING FEES FOR THE CALL OR TEXT MESSAGE. I UNDERSTAND, ACKNOWLEDGE AND AGREE THAT THE COLLECTORS MAY CONTACT ME BY AUTOMATIC DIALING DEVICES AND THROUGH PRE-RECORDED MESSAGES. I FURTHER AGREE THAT THE COLLECTORS MAY CONTACT ME USING EMAIL AT ANY EMAIL ADDRESS I PROVIDE TO THE FACILITY OR IS ASSOCIATED WITH MY ACCOUNT.

SIGNATURE____ DATE__________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, ________________________________, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PRINT NAME__________________________ SIGNATURE__________________________ DATE__________

--------------------------------------FOR OFFICE USE ONLY--------------------------------------

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGMENT COULD NOT BE OBTAINED BECAUSE:

___INDIVIDUAL REFUSED TO SIGN	___AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
___COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT	___OTHER (PLEASE SPECIFY)