Legacy Dental Arts

Insurance Policy

Legacy Dental Arts realizes how important insurance benefits are, we ask that you carefully review your policy and/or contact your insurance so that you are aware of your benefits and frequencies, limitations and/or restrictions. **Please be informed that dental insurance is a contract between you and your insurance company, as a courtesy we will assist you with filing your insurance claim(s).** Your Dentist is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly maximum and anything over that will be your responsibility. If any dental services have been provided for you by another provider within your benefit year those fees will count toward your maximum as well. If you have two insurance policies, please be aware of both policies. **Not all policies will cover remaining portions after your primary insurance has paid**. Please provide Legacy Dental Arts with your insurance card at the time of dental coverage change and/ or new policy. **It is your responsibility to provide us with any future changes with your insurance.** By initialing here I acknowledge that I have read and understand this _____.

Please Initial Here

Financial Policy

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees as a courtesy. **Remember that there is always a possibility that your insurance may not pay the estimated amount and that as a patient, parent and/or guardian you are responsible for your balance.** It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account.

Financial options that we provide at this time are: Cash, Check, Major Credit Cards (Visa, Master card, American Express, and Discover), and Care Credit. **Should collections become necessary, it is the patient's responsibility to pay all collection agency fees _____.**

Please Initial Here

Appointment Commitment

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time.

***If circumstances occur and it's necessary for you to change your scheduled appointment, we request that you give us at least 2 business days notice.**

A broken appointment (an appointment in which one does not call or show up) is not acceptable.** ***If you have scheduled a reserved time and do not show up or call you may be assessed a $50.00 charge. By initialing I acknowledge that I have read and understand this policy _____.

Please initial Here

I have read and understand the previous pages of information. To the best of my knowledge, I have answered all the questions with the correct information knowing that by answering incorrectly could be potentially dangerous to my health. If there is any change to my medical status I will inform the dentist so that he may provide me with the quality of care that I require._____

Please Initial Here

Consent for Use and Disclosure of Health Information/HIPAA

I, _____,have had the full opportunity to read your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent for your use and disclosure of my protected health information, to carry out treatment, payment activities and healthcare operations.

My Personal and account Information may be Released to:

1._____

2._____

_____

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Please Sign and Date here