Stony Dental Care

3996 Walden Avenue
Lancaster, N.Y. 14086
716-683-2001

FINANCIAL POLICY

The following is a summary of our Financial Policy. These may change without notification from our office.

We participate in most insurance plans. However, this DOES NOT mean that we accept the insurance as payment in full. Most policies still have a co-pay and/or deductible. These vary, based on your anticipated insurance coverage. We will be happy to file a claim for you, provided all co-pays have been made and we are provided with all the necessary information at the time of your appointment. Please contact us, in advance of your appointment with any insurance changes.

Your insurance is a contract between you and your dental carrier. Ultimately, it is your responsibility to know the details of your coverage. Should you have any questions, contact your insurance company for plan coverage and benefits. Submitting a pre-treatment estimate to your insurance company is the most accurate way to determine your coverage and patient share for major services. However, keep in mind that it may take several weeks to get a response. If treatment is started prior to receiving a response, you will be responsible for any portion not covered by your insurance. Once our office has been reimbursed for all insurance claims, the patient (or responsible party) is responsible for any unpaid balance.

Full payment is required at the time of service, of anyone with no dental insurance and any insurance companies that we DO NOT participate with. These companies may reimburse you directly. For patients with insurance we participate with, deductibles and co-insurances (patient share) are due at the time of service. . We also participate with Care Credit. This is used exclusively to help you pay for your treatment. For more information, please feel free to ask our office or call Care Credit at 1-866-893-7864.

A $35.00/$50.00 (Hygiene/Doctor) missed appointment fee will be charged to your account for all missed appointments and or same day cancellations. Please give our office at least 24 hours notice if you need to cancel or reschedule an appointment.

Should your account become delinquent, you will be responsible for any collection and/or attorney fees. A $25.00 fee for returned checks and any bank charges will also be your responsibility.

If your account is past due over 90 days, without prior arrangement, we reserve the right to end the Doctor/Patient relationship. If this occurs, you will be dismissed from our practice and we will provide you with EMERGENCY TREATMENT ONLY, for 30 days from the dismissal date.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK PRIOR TO THE BEGINNING OF YOUR TREATMENT.

Signature: _____ Date: _____

Stony Dental Care, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient's Name: _____

Patient's Date of Birth: _____

Notice to Patient: By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer. You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

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Patient's Signature or Signature of Patient's Representative Date