

Patient Name: _____

Date _____

Conditions of Treatment and Payment (Office Policy Consent)

As a condition of your treatment by Next Century Dental, all treatment must be paid in full at the time services are rendered. Payment in full is expected at the time of services unless approved financial arrangements have been made and promissory notes have been signed in advance of treatment being started. The patient and responsible party are responsible for all services incurred on the above patient. As a courtesy to our patients, the staff of Next Century Dental will file your insurance claim and will ASSIST in collecting from your insurance company. HOWEVER, Next Century Dental does not render services on the assumption that our charges will be paid by any insurance company. The estimated "patient portion" is ONLY an estimate and is calculated as a courtesy to our patients. Many dental offices expect their patients to pay dental services in full and let the insurance company reimburse the patient/responsible party. As a courtesy to our patients, the staff of Next Century Dental will calculate an estimate of the insurance benefits contingent on the assignment of benefits. However, in the event that the insurance company pays less than the estimated amount, the patient/responsible party are fully responsible for any unpaid balance.

I authorize Next Century Dental to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to any third party payors and or health practitioners. I authorize and request that my insurance company pay all insurance benefits to Next Century Dental otherwise payable to me. Next Century Dental does not involve itself in any split account responsibilities. NCD's policy of payment with regard to the children of divorced parents rest with the parent who seeks the dental/ortho treatment. Any credit card on file may be used to pay an outstanding balance. If payment is made in advance for any treatment, there will be no refund of payment, only in office credit (valid for 18 months from payment date). Additionally, I grant my permission to Next Century Dental to use any photos that include me or my teeth or any other information for advertising or teaching purposes. I have the right to revoke this permission by submitting such in writing and delivering it via certified mail revoking such permission effective 10 days after the receipt of the certified notification.

I grant my permission to Next Century Dental & its employees/agents to telephone me at home or at my work to discuss matters including, but not limited to this form, my account, & my dental treatment.

I understand that by signing I fully understand this office policy.

Signature of patient (or parent if minor)

Relationship to Patient

Date

Insurance Consent

As a courtesy, Next Century Dental will file your insurance claim and assist in collecting from your insurance company. However, Next Century Dental does not render services on the assumption that our charges will be paid by the insurance company. The "patient portion" is ONLY an ESTIMATE and in the event that the insurance company pays less than the estimated amount listed, YOU ARE RESPONSIBLE FOR THE UNPAID PORTION. WE would also like to inform you that most, but not all, insurance companies allow the benefit of amalgam fillings (silver/mercury) and the benefit of full cast crowns (metal/gold) on posterior (back) teeth.

Our dentists provide porcelain high noble metal crowns and all of our dentists, with the exception of one, perform composite (tooth colored) fillings. The cost difference between the two is usually minimal. YOU WILL BE RESPONSIBLE for the amount your insurance company does not pay. Please ask the Patient Advocate or any member of our staff to see which benefit we ESTIMATE your insurance company to pay. Please advise your dentist if you would rather have the amalgam fillings or the full cast crown.

Signature of patient (or parent if minor)

Relationship to Patient

Date

HIPAA Consent

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used but is not mandatory for me to sign in order to: conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payors, conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by Next Century Dental of its Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information and have been provided with a copy of their Notice of Privacy Practices prior to signing this consent. I understand that NCD has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization to obtain a copy of such.

I understand that I may request in writing by certified mail to request restrictions on how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, you will abide by such restrictions. I understand that I may revoke this consent in writing by certified mail at any time except to the extent that you have taken action relying on this consent.

Signature of patient (or parent if minor)

Relationship to Patient

Date

Accuracy Certification:

I certify that I have read and understand all the information contained herein to the best of my knowledge. I have answered all the questions contained herein accurately and truthfully. I understand that providing incorrect or incomplete information can be dangerous to my health.

Signature of patient (or parent if minor)

Relationship to Patient

Date